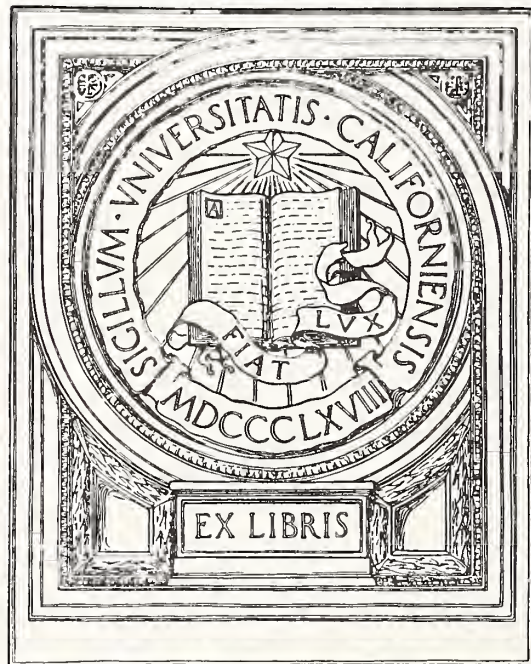


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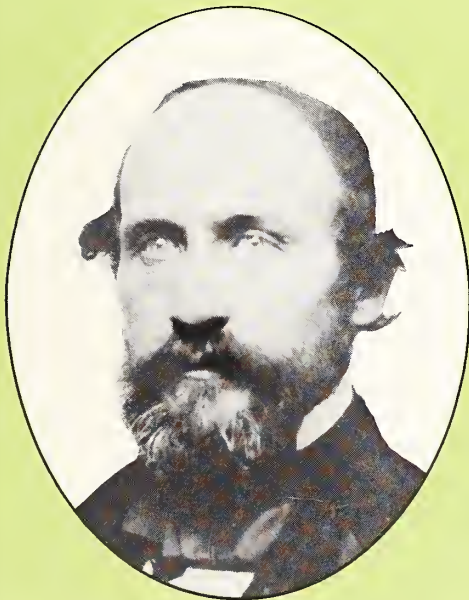


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KANSAS MEDICINE

Volume 88, Number 1, January 1987 ISSN 8755-0059



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1826-1885
Lieutenant Governor

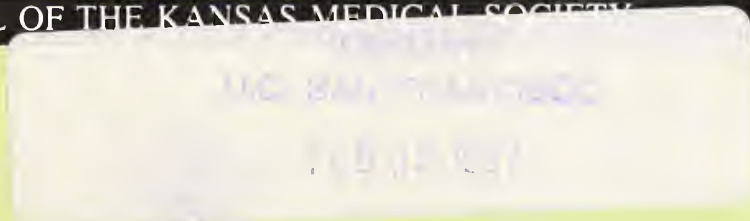


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Secretary of State

125 YEARS OF KANSAS STATEHOOD

1987 Legislature Convenes	1
Special Feature: Men of Their Time	21
KMS Newsletter	16a

THE JOURNAL OF THE KANSAS MEDICAL SOCIETY



KANSAS MEDICINE

• The Journal Of The Kansas Medical Society •

Volume 88, Number 1, January 1987

Contents

Special Feature

- Men of Their Time — David E. Gray, M.D., Topeka 21

Miscellaneous

- A Personal View: *In Search of a Health Care System for Farmers* — Donald D. Goering, M.D., Coldwater .. 27
Classified Advertisements 30
Editorial Comment: *Reaction to Accommodation* 24
Guidelines for Level III Perinatal Centers in Kansas 12
Impaired Physician Program Directory 32
Information for Authors 32
Kansas House of Representatives 4
Kansas House of Representatives District Map 8
Kansas Legislative Leadership 1
Kansas Senate 4
Kansas Senate District Map 6
KMS Newsletter 16a
Medicina et Lex: Drug Dispensing — Wayne T. Stratton, J.D., Topeka 25
Physician Directory 30
President's Message 23
Upgrading Regionalized Perinatal Care in 1987 10

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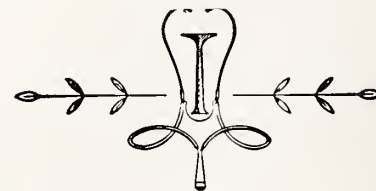
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Kansas Legislative Leadership

The Kansas Legislature convened January 12 for what may be one of the most difficult sessions in many years. The sagging economy has left the state far short of its revenue projections, necessitating unpopular reductions in many government programs.

Against this somewhat grim backdrop, a new set of legislative and executive leadership has been sworn into office. Unquestionably, the challenges

that face new Governor Mike Hayden and Lieutenant Governor Jack Walker, M.D., will demand a creative approach to problem solving. Likewise, the legislature will have a sizable task in matching scarce resources with rising public demand for services.

These leaders will guide the state during the next few years. More than almost any other factor, the opinions and philosophies of these elected officials will determine the course of Kansas government.

Mike Hayden
Republican
Governor

Mr. Hayden, 42, has been in the insurance business in Atwood. He was first elected to the Kansas House of Representatives in 1972, and served as chairman of the House Ways and Means Committee for four years. He was Speaker of the House of Representatives for four years, beginning in 1983. A conservative with exceptional ability in the area of the state's finances, Mr. Hayden brings to the office of Governor a reputation of being independent and tenacious.



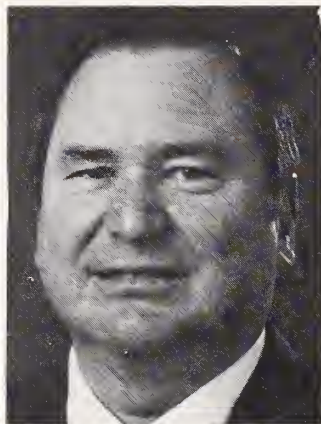
Jack D. Walker, M.D.
Republican
Lieutenant Governor

Dr. Walker, 64, was graduated from the University of Kansas School of Medicine in 1953. He practiced family medicine in Girard and Pittsburg until 1963 when he became associate dean at UKSM. In 1971, he was appointed first chairman of the newly created Department of Family Practice. In 1984, he was elected to the Kansas Senate from Johnson County, and has served on the Public Health and Welfare Committee for the past two years. Since his election as Lieutenant Governor, he has resigned his Senate seat as well as his position with UKSM, from which he was on leave of absence. Governor Hayden has appointed Dr. Walker Secretary of the Kansas Department of Health and Environment, a cabinet level appointment. Dr. Walker is a member of the KANSAS MEDICINE Editorial Board.



Robert V. Talkington
Republican
President of the Senate

Mr. Talkington, 58, is an attorney from Iola, and served two terms in the House of Representatives prior to his election to the Senate in 1973. He was elected Senate Vice President in 1977, Majority Leader in 1981, and President in 1985. In addition to his duties as President, he alternates as chairman or vice chairman of several joint legislative committees and serves on the Senate Ways & Means and Judiciary Committees.



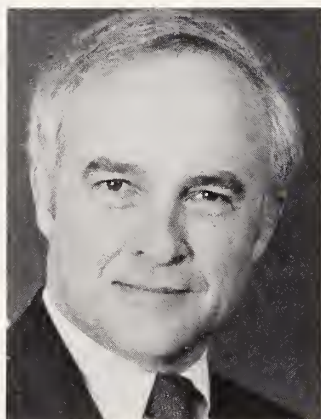
James D. Braden
Republican
Speaker of the House

Mr. Braden, 52, is in the insurance business and is serving his sixth term representing Clay Center in the House of Representatives. He is chairman of the Legislative Commission on Kansas Economic Development and the Calendar & Printing Committee; he also serves on the Legislative Coordinating Council, the State Finance Council and the Kansas Public Agenda Commission, and is a member of House committees on Interstate Cooperation, and Legislative Congressional & Judicial Apportionment.



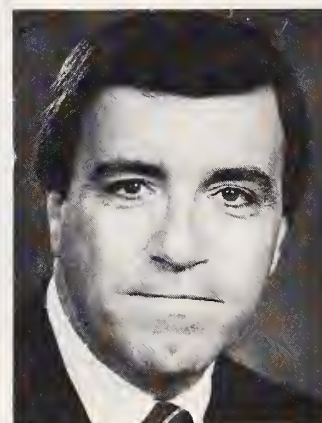
Paul "Bud" Burke
Republican
Senate Majority Leader

Mr. Burke, 53, is in the investment banking business in Leawood. He was initially elected to the Kansas Senate in 1975 after serving one term in the House of Representatives. He currently is chairman of the Calendar Committee and Vice Chairman of the Legislative Interim Tort Reform and Liability Insurance Committee. Other current committee appointments include Organization Calendar & Rules, Budget, Judiciary, Financial Institutions & Insurance, Interstate Cooperation, Assessment & Taxation, and Legislative & Congressional Apportionment. He also serves on the executive committee of the National Conference of State Legislatures.



Michael Johnston
Democrat
Senate Minority Leader

Mr. Johnston, 41, is in the mortgage brokerage business in Parsons. He was elected to the Kansas Senate in 1976, and became Senate Minority Leader in 1985. He serves on the Apportionment, Elections, Governmental Organization, Interstate Cooperation, and Ways and Means committees.



Joe Knopp
Republican
House Majority Leader

Mr. Knopp, 34, is an attorney from Manhattan. He was first elected to the Kansas House of Representatives in 1980, and was recently elected Majority Leader by his Republican colleagues. Mr. Knopp has chaired the House Judiciary Committee and in 1985 chaired the Special Interim Committee on Medical Malpractice.



Marvin W. Barkis
Democrat
House Minority Leader

Mr. Barkis, 44, is an attorney from Louisburg in Miami County. He was first elected to the House of Representatives in 1978, and was elected Minority Leader in 1984. He has been a member of the House committees on Assessment & Taxation, Education, and Judiciary. He currently serves on the Calendar & Printing Committee, and on the Government Operations Committee of the National Conference of State Legislatures.



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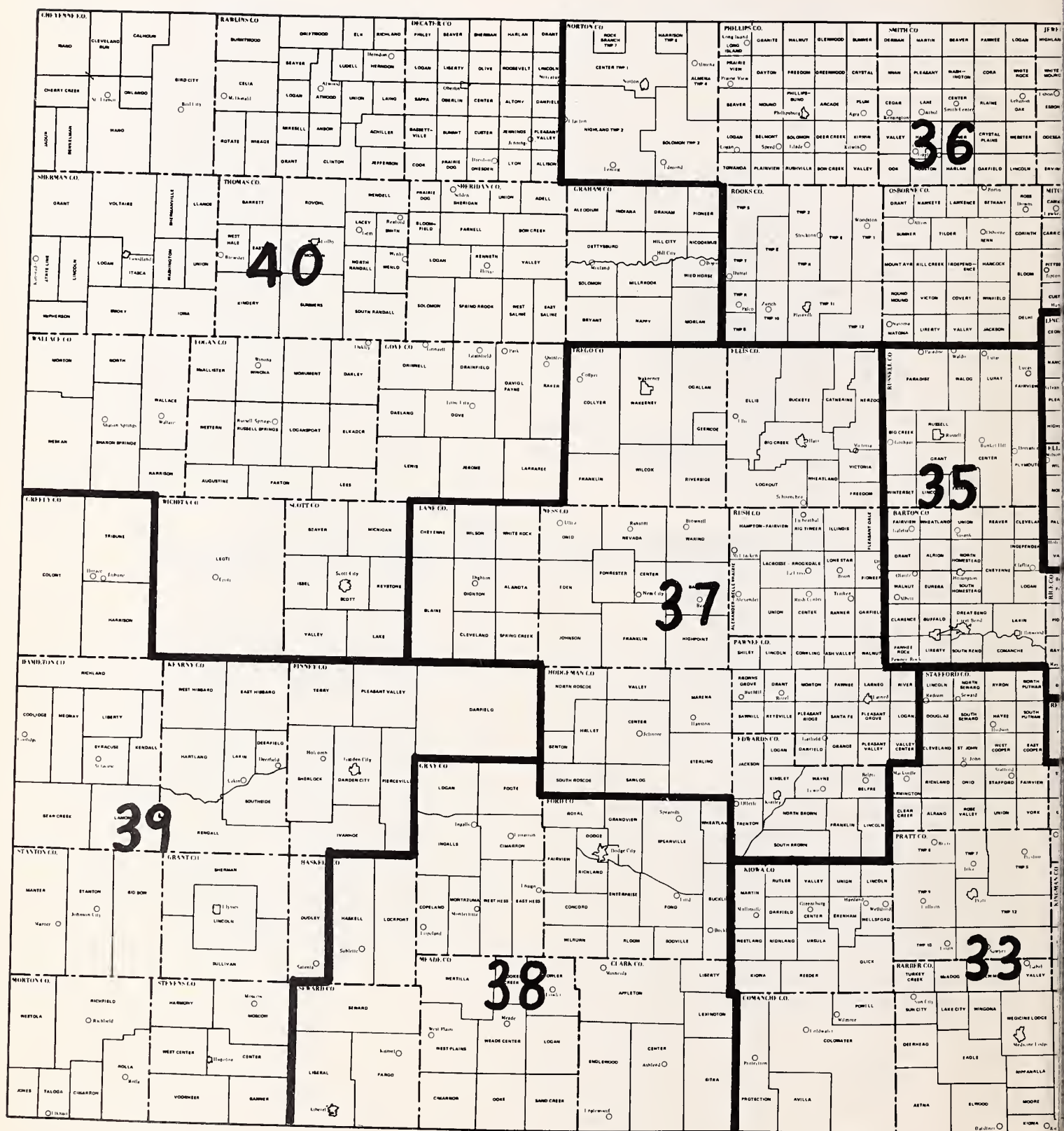
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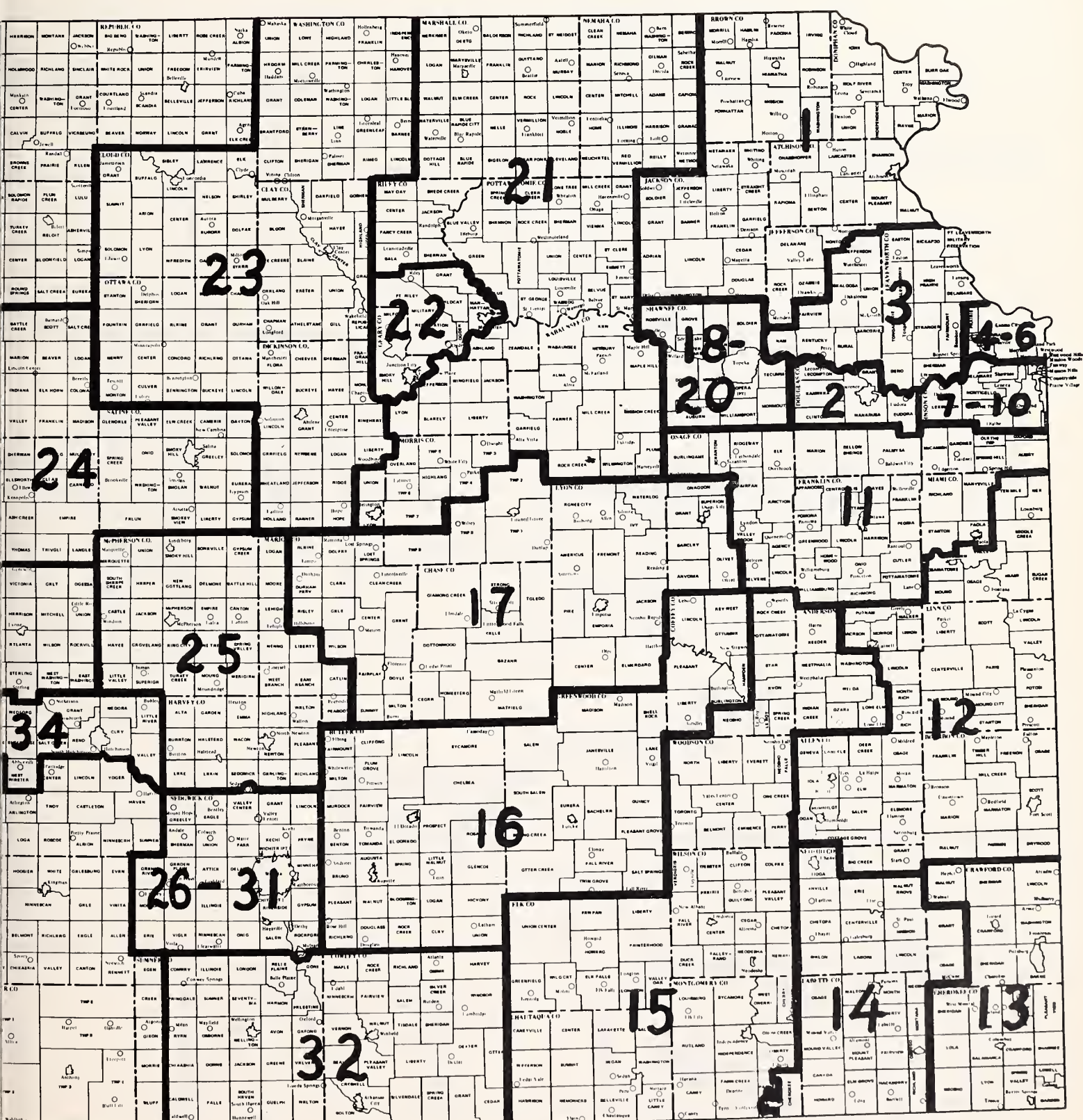
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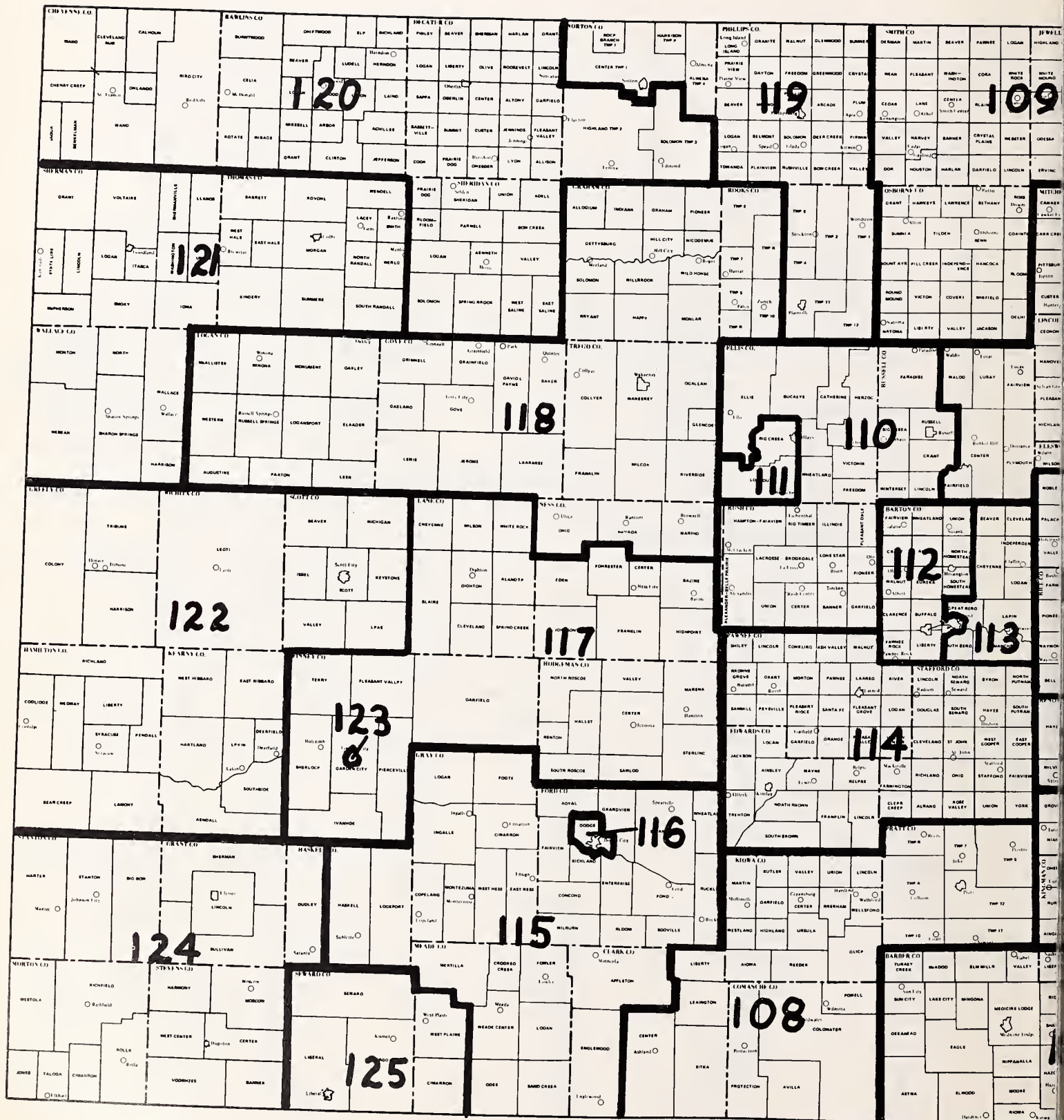
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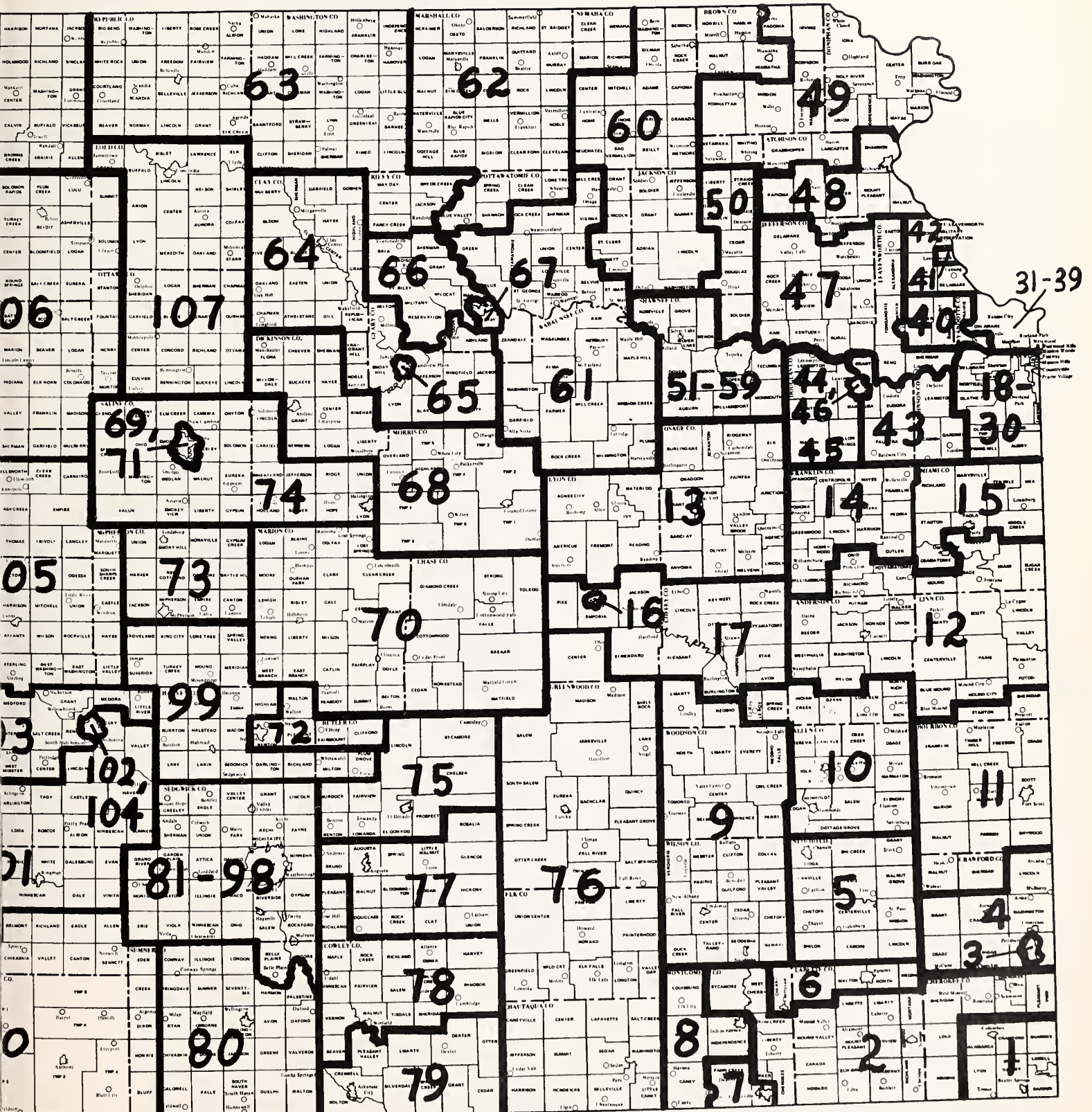


Senate Bill 220, 1979 Session



Kansas House Districts Created





Upgrading Regionalized Perinatal Care in 1987

THE KANSAS Regional Perinatal Program, operating under the auspices of the Perinatal Medical Council, strives toward ever improving perinatal care throughout the state. A reevaluation of the program's direction took place in June 1986, at a meeting in Wichita. Participants were perinatal team members from Kansas Level II and III hospitals, as well as third-party-payer organizations. Fourteen of the sixteen perinatal hospitals were represented. A comprehensive and critical look was taken at perinatal regionalization — as it should be and as it actually exists in Kansas. Problem areas were identified and a list compiled. Participants were divided into three groups — physicians, administrators including third-party-payers, and nursing personnel. Solutions and/or recommendations were developed to address the concerns of each group, although all three groups worked from the same master list of problems. These were then shared in a common conference, and summaries of each group's thoughts were submitted to the Perinatal Medical Council.

Two topics emerged as central themes of the conference: (1) the need for uniform risk assessment during pregnancy, and (2) the role or value of cooperative agreements between institutions, particularly Level III perinatal centers and Level II hospitals. The uniform assessment of risk would help standardize care to all segments of the population and lay groundwork for full regionalization of care. Cooperative agreements would consider perinatal patient care and regional education in order to maximize roles and functions of all levels or designations of hospitals.

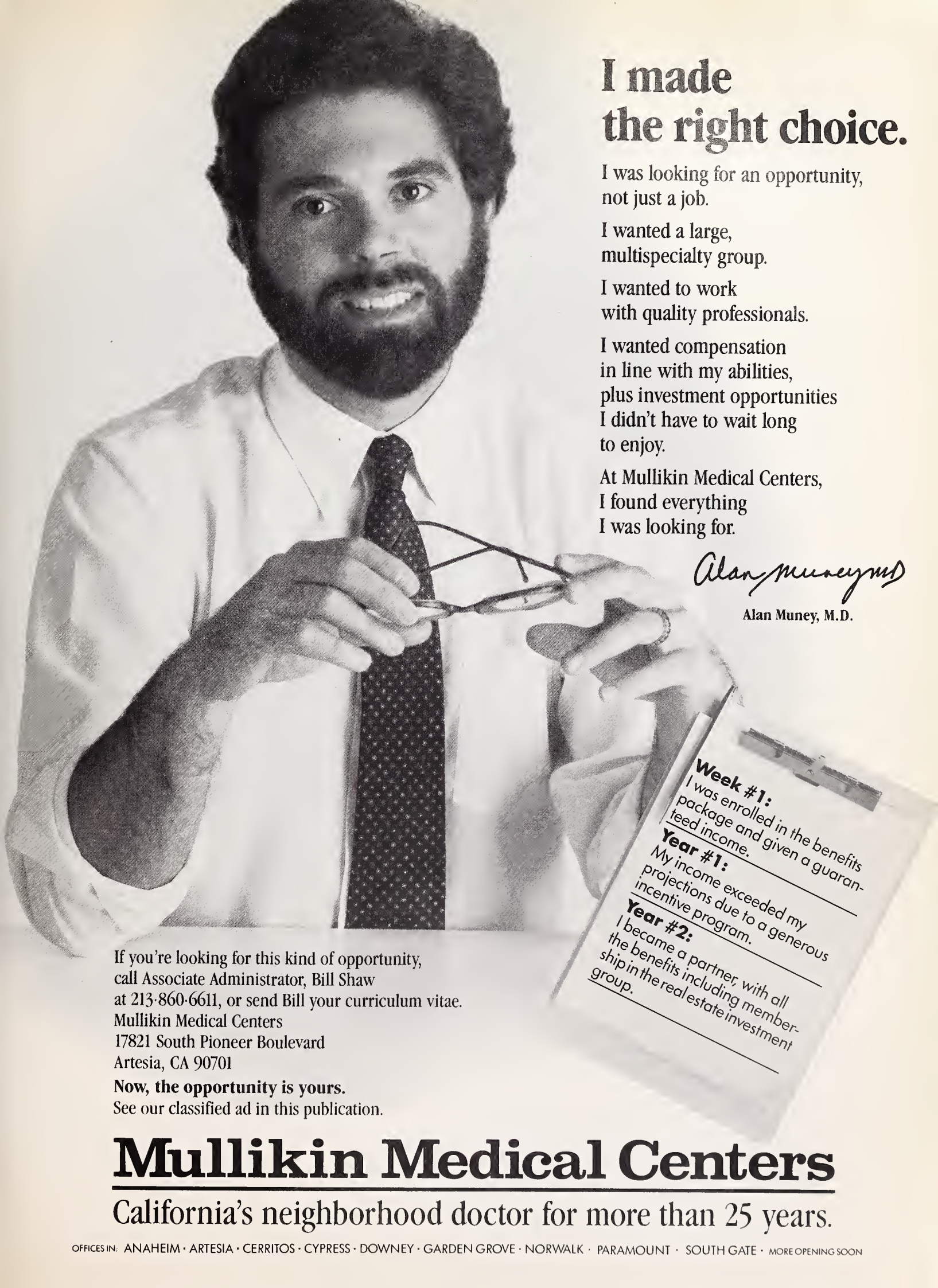
In association with the discussions of the above topics by all three groups, two groups (physicians

and nurses) discussed the role of Kansas Perinatal Medical Council, and two groups (physicians and administrators) discussed the current status of Kansas regionalized perinatal care and the dilemmas of hospitals designated as Level II centers. Although emphasis varied somewhat, these subjects were interrelated because the Council is perceived to have a potential role in the certification process of the various level centers.

Several additional topics were discussed by a single group: the role of nurses in regionalized perinatal care (nurses); funding of transports to and from perinatal centers (administrators); and the need for funding and reimbursement of preventive maternal and newborn care (administrators).

The statements and conclusions of each group are being used to formulate policies of the Perinatal Medical Council on problems in Kansas, potential solutions, and the specific role of the Council in regionalized perinatal care. The Council will actively promote development of cooperative agreements and mediate and facilitate discussions toward these cooperative agreements. The Level III Perinatal Centers (University of Kansas and Wesley Medical Centers) are to develop the initial pilot agreements under the supervision and guidance of the Council. In addition, the Council volunteers to designate levels of care in an effort to support individual hospitals and their efforts to more efficiently and effectively promote optimal care. The Council continues to request input from all those associated with perinatal care in Kansas.





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Guidelines for Level III Perinatal Centers in Kansas

Purpose

These guidelines have been prepared to assist Level III maternal and newborn perinatal care centers to plan, implement, and evaluate all related services. The information represents a synthesis of materials available through national publications, other state perinatal guidelines, Committee on Perinatal Health, the 1983 *Guidelines for Perinatal Care* written jointly by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics, and recommendations from Kansas perinatal consultants. These guidelines should further complement the Level I and II Guidelines which were formulated previously by the Perinatal Medical Council of the Kansas Regional Perinatal Care Program.

Introduction

The Kansas Perinatal Program is based on goals and objectives directed toward the entire perinatal population. These goals and objectives address service, education, and research to promote better care through expansion of professional knowledge and skills, proper allocation of resources, and perinatal outcome evaluation.

Establishment of a Level III Perinatal Center requires significant commitment toward attaining these goals. Of all levels of perinatal care, the Level III Center has the highest obligation to serve, support, provide educational programs, and evaluate perinatal needs within its region. A financial commitment apart from direct patient care is necessary.

Each institution that provides Level III services should serve a region with 8,000-10,000 deliveries per year. To support additional Level III regional responsibilities, the center should have approximately 2,000 deliveries (or serve a disproportionate number of high risk patients), and several hundred transfers per year.

A Level III Center should operate within the context of regional perinatal care needs. Awareness of

these needs can be obtained through local and regional health systems agencies as well as the Kansas Perinatal Program. Leadership and administrative roles should be clearly identified by Level III Centers due to the complexity of agencies involved as well as the critical condition of the patients. A broad base of support and the establishment of a liaison between health systems and health care providers is critical to the implementation and success of Level III Centers.

Definition of Level III Center

A Level III Perinatal Care Center is a hospital based unit capable of providing maternal, fetal, newborn, and neonatal primary prevention services for normal and high risk patients. Services should also be available for serious maternal-fetal and neonatal illnesses and abnormalities. A close working relationship needs to be established with national tertiary centers to obtain consultation regarding highly unusual cases.

Level III Centers should also provide leadership in preparatory and continuing education to improve the overall quality of care in the region. Involvement in initiation, development, and evaluation of new concepts and techniques in perinatal care and active participation in clinical and basic research related to perinatal health should be on-going in such a center.

The intensity of care provided in a Level III Center will vary based on the results of the patient's risk assessment; however, patient needs should be met regardless of the level of care required. The provision of this care will require the availability of consultation or direct services on a 24-hour basis. An organized transport system should be center-based to provide transport of patients to and from the center to guarantee availability of Level III care within the shortest possible time within the center's region.

Level III Services

Services provided at a Level III Center should include, at a minimum, those provided by Level I and II Centers. (See Guidelines for Level I and II Perinatal Care Centers in Kansas.) In addition, the Level III should provide:

These guidelines were approved by the Executive Committee and Perinatal Medical Council of the Kansas Regional Perinatal Care Program. Requests for further information should be directed to Kansas Perinatal Care Program, Kansas Department of Health & Environment, Topeka KS 66620.

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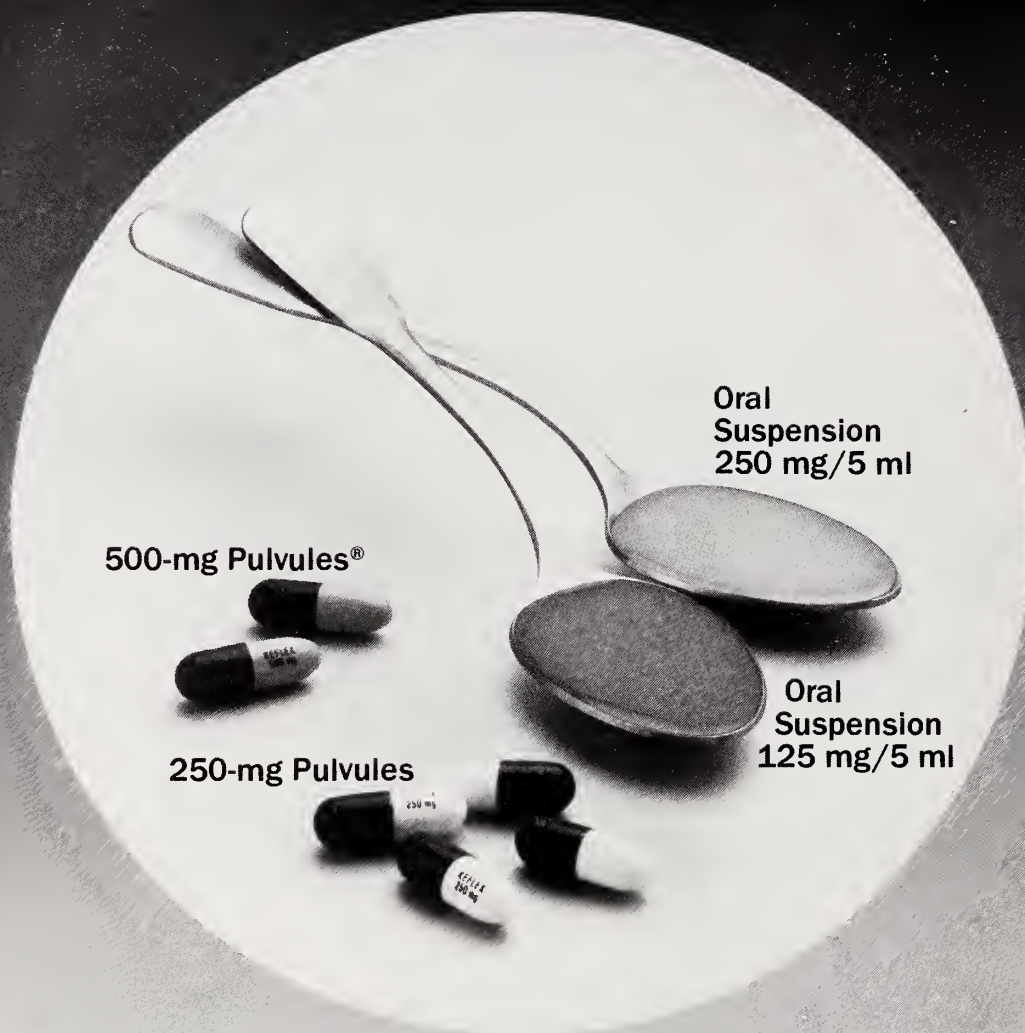


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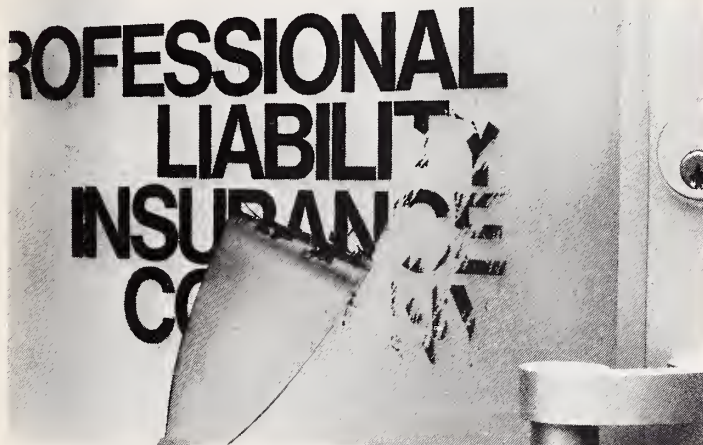
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- Availability of a nutrition team comprised of a registered dietitian, physician, and nurse to provide assessment of nutritional status, development and implementation of a management plan, and counseling for special dietary modifications and follow-up.
- Social work services available on a 24-hour basis.
- Prenatal education program for patients and their families, to include, but not limited to, prenatal risk reduction, preparation for breast feeding, physiological and psychological aspects of and preparation for childbearing, and nutrition.
- Laboratory facilities providing estriols, photo-

metric analysis of amniotic fluid, lecithin/sphingomyelin ratios, and genetic testing.

- Capability to administer and evaluate prenatal testing to include, at a minimum, stress and non-stress tests and amniocentesis.
- 24-hour radiologic and sonographic capabilities.
- 24-hour blood bank service and micro-blood study capabilities with ability to respond to STAT request.
- Capability to complete prenatal diagnosis and provide genetic counseling services.

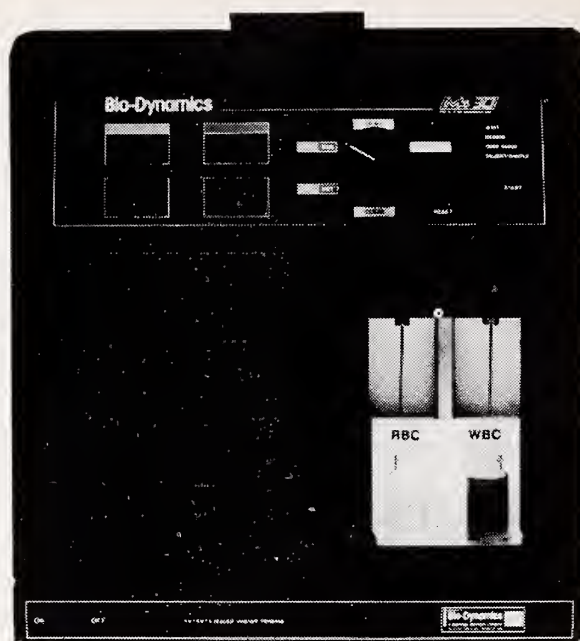
Intrapartum Care

- Facilities for intensive intrapartum care.
- Labor beds and delivery rooms to be consistent with anticipated daily average of postpartum patients.
- 24-hour labor and delivery coverage by registered nurses. A minimal staffing pattern of two registered nurses for every three labor patients with additional staffing appropriate to the volume and type of high risk patients.
- 24-hour in-house physician staffing capable of evaluating normal and high risk obstetrical patients and performing operative obstetrics.
- 24-hour availability of social work, nutrition services, and consultation.

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- Capability to perform cesarean section in less than 30 minutes (preferably within 15 minutes) from indication.
- 24-hour in-house anesthesia services.
- 24-hour blood studies on STAT to include, at a minimum, microtechniques for CBC with platelets for mother and fetus, scalp pH and blood sugar.
- 24-hour blood bank service. Fresh type O/Rh negative blood and fresh frozen plasma shall be available at all times. The blood bank should also have special expertise in banking and administration of component therapy.
- 24-hour availability of realtime ultrasound (Level II type) in the labor and delivery unit.
- Capability for continuous electronic maternal-fetal monitoring and interpretation of EFM records.
- Capability to perform maternal and infant cardio-respiratory resuscitation and intubation, and intravenous therapy.
- 24-hour pharmacy service including preparation of intravenous fluids.

Postpartum Care

- 24-hour coverage by registered nurses and physicians for monitoring and evaluation of patients

immediately post delivery and throughout the postpartum period. Nursing staff should include, at a minimum, two to three registered nurses for every 12-16 patients without complications; and one additional registered nurse for every two to five post-operative or other high-risk patients.

- Access to the nutrition team to develop and implement continuity of nutrition care plans.
- Access to social work services on a 24-hour basis.
- Structured discharge planning program to provide followup and/or referral to physician, social service, and public health agencies appropriate to patient needs.
- Patient and family education program relating to patient and/or newborn status, care, breast feeding, and information that would impact plans for future pregnancies.
- Capability to provide genetic testing and counseling services.

Neonatal Care

- Services to provide care for the normal neonate, including specimen collection for newborn screening.
- Neonatal intensive care unit staffed and equipped

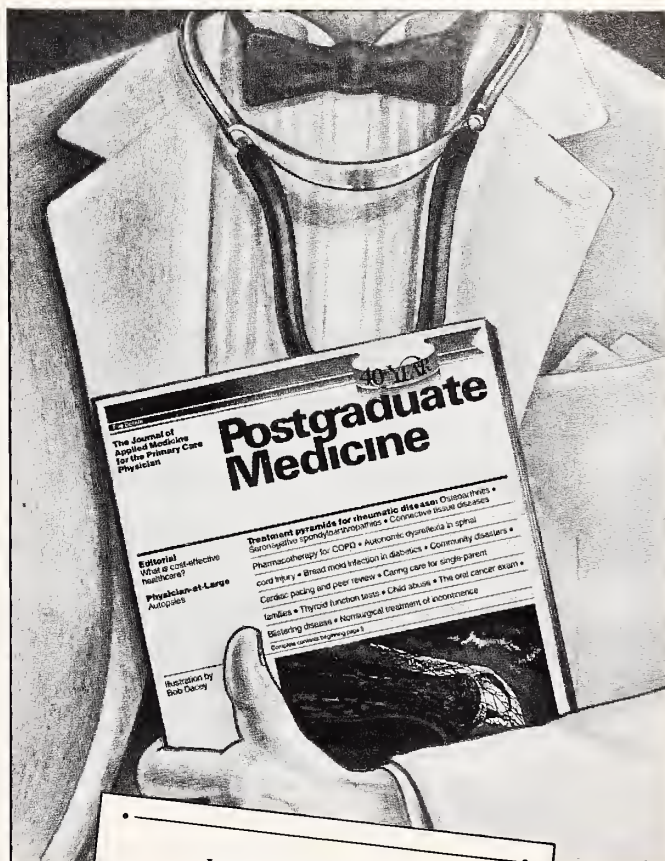
to treat the critically ill neonate delivered in or transferred to the Level III Center to include at a minimum, capability to perform continuous cardio-respiratory monitoring, measuring Doppler blood pressure and central arterial and venous pressures, and exchange transfusions. Minimum of ten neonatal intensive care beds at an occupancy rate of 75%.

- 24-hour physician coverage.
- 24-hour coverage by registered nurses. Minimum staffing ratios: (a) normal newborn nursery — one registered nurse for every eight to ten newborns and one nursing staff (R.N. preferred) for every additional ten newborns; (b) neonatal intensive care nursery — one to two registered nurse(s) for every two critically ill infants; and (c) NICU continuing care unit(s) — one registered nurse for every four infants.
- Availability of a nutrition team comprised of a registered dietitian/nutritionist, neonatologist, and nurse for the evaluation, nutritional management, and followup of infants with complex medical and surgical problems. Support regarding breast feeding should also be available.
- Access to social services on a 24-hour basis.
- In-house clinical laboratory services on a 24-hour basis with capability to perform micro-studies to include at a minimum blood gases, bilirubin, blood sugar, CBC with platelets and clotting studies, and electrolytes necessary for newborn assessment. Test results for hematocrits and blood gases to be available within 15 minutes.
- Equipment and a trained team for transport of maternal/fetal and newborn patients from referring hospitals to the Level III Center.
- Staff prepared in neonatal airway management including laryngoscopy, endotracheal intubation, artificial ventilation, suctioning of airways, cardiac massage, and biochemical resuscitation.
- Consultation and surgical assessment with appropriate subspecialist available on a 24-hour basis.
- 24-hour radiology service including portable machine for use in the nursery (15-30 minute turn around time for STAT request).
- Availability of ultrasound on a 24-hour basis.

Consultation and Transfer

The potential for complications and the need for transfer is ever present in centers that offer obstetrical care. Level III Perinatal Centers, by virtue of their volume of complicated deliveries, require availability of full time perinatal and neonatal staff for 24-hour consultation. This consultation should

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January

Symposium: Biliary Tract Disease

Special Article: Gastroenterology 1947-1987 Joseph B. Kirsner, M.D.

February 1

Symposium: Focus on Family Practice Donald E. DeWitt, M.D.
coordinator

Special Article: Family Practice 1947-1987 W. Jack Stelmach, M.D.

February 15

Symposium: Emergency Medicine Robert E. Rosenthal, M.D.
coordinator

Special Article: Emergency Medicine 1947-1987 James D. Mills, M.D.

March

Symposium: Otolaryngology in Primary Care Thomas J. McDonald, M.D.
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be readily available to health care providers within the referral region. Consultation with attending staff regarding maternal/fetal or neonatal questions or complications should be encouraged and easily facilitated with a toll-free number. When transfer is indicated, optimal management before and during the transfer is best facilitated by the perinatal team going to the referring hospital with the necessary supplies and equipment.

If Level III neonatal services are anticipated, maternal transfer is encouraged when possible. Therefore, an on-call readily available perinatal transport team functioning under medical direction of the perinatologist and neonatologist is an integral part of Level III perinatal services. The Level III Center has the responsibility to be actively involved in facilitating transfer of critically ill perinatal patients and in the training and evaluation of the transport team.

Administrative Direction

A full time director, or co-directors, who is a qualified physician(s) should be designated to assume the administrative responsibilities of the Level III Perinatal Center. The obstetrical component director should be a board eligible/certified perinatologist. The neonatal component director should be a board eligible/certified neonatologist.

The specifics for the organizational interaction can be determined by each Level III center. The physician director(s) or a designee has the responsibility to integrate and coordinate a system of consultation, in-service education, communication and coordination with primary, secondary, and other tertiary units. In addition the physician director(s) should collaborate with other members of the perinatal team to define and establish appropriate protocols and procedures for obstetrical and neonatal patients. The physician director(s) should work closely with hospital administration, community agencies, the Kansas Regional Perinatal Care Program, and Kansas Department of Health and Environment. The physician director(s) should also attend and/or designate representatives (physicians, nursing, and other support staff) to participate in meetings and activities sponsored by the Kansas Perinatal Care Program.

Perinatal Team Staff

Physicians: Additional obstetrical and pediatric physician support will be essential for Level III care. Obstetrical support can be provided by board eligible/certified obstetricians with experience, inter-

est, training, and/or certification in maternal-fetal medicine. Pediatric support can be provided by board eligible/certified pediatricians with experience, interest, training, and/or certification in neonatal-perinatal medicine.

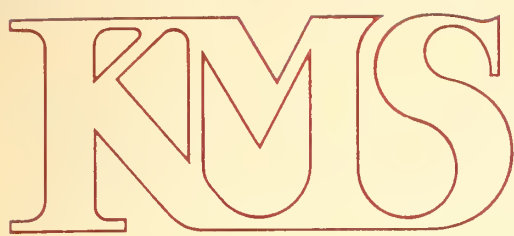
Specialists and Subspecialists: These physicians will represent both surgical and medical specialties for the adult and neonate. Consultation should be available regarding genetics, renal function, metabolism, cardiology, neurology, hematology, endocrinology, gastroenterology-nutrition, infectious disease, pulmonary, immunology, and pharmacology. Pediatric surgical subspecialists — including cardiovascular, plastic, neurosurgery, orthopedic, urologic, ophthalmologic, and ENT — should also be available for consultation and care. Perinatal management and on-going evaluation will also be enhanced by the support and participation of pathologists interested in the various laboratory and tissue pathology related to perinatal medicine.

Nursing: Nursing services in the Level III Perinatal Center should be directed by a registered nurse with a Master of Nursing degree (emphasis in Maternal and Child Health) who has proven experience and background in management and clinical services. Nursing services in antepartal, labor and delivery, postpartum, and neonatal areas should be under the direction of a registered nurse with a Bachelor of Nursing (Master's in MCH preferred) who also has proven competency in the care of the normal and high-risk patient and experience in leadership and management. Other nursing staff (B.S.N. preferred) in these areas should be prepared in management of the normal and high-risk maternal patient to assure optimal care.

Nurses working in all areas of the perinatal unit should possess knowledge and demonstrate clinical competence in detecting deviations from normal and the management of perinatal emergencies. Orientation, in-service, and continuing education courses must be available.

It is recommended that B.S.N. prepared (Master's preferred) clinical coordinators be available to facilitate communication between the perinatal team members, provide staff orientation and in-service education, serve as clinical consultants, and establish standards of care. Two coordinators are suggested — one for the neonatal unit (normal and NICU) and one for the prenatal, intrapartal, and postpartum units.

Anesthesia: This service should be directed by a board certified anesthesiologist with additional experience and/or training in perinatal anesthesia.



Kansas Medical Society Newsletter

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JANUARY 1987

MALPRACTICE UPDATE

As was expected for some time, all but one of the major professional liability companies in the Kansas market have filed for rate increases, generally effective in 1987. PHICO (formerly Pennsylvania Casualty) was the first to receive approval for an increase in the range of 35% across the board. Medical Defense Insurance Co., the physician-owned mutual from Springfield, Missouri, was granted a whopping 60% increase. St. Paul, one of the largest insurers, has filed for, but not yet received, an increase in the 65% range across all risk classifications. St. Paul's last increase was 1½ years ago.

The only major company not filing for an increase was Medical Protective Company of Fort Wayne, Indiana. Medical Protective took two increases in 1985, but pledged to hold the line until 1988, if possible.

These increases come on the heels of the most significant tort reform legislation ever passed in Kansas. Unfortunately, the award limits and other reforms in HB 2661 don't apply to claims already in the pipeline, which are still driving premiums skyward. In time, the provisions in HB 2661 will stabilize rates and there has already been a reduction in the premium surcharge for \$1 million coverage in the Health Care Stabilization Fund. However, in the short term, the rising premiums are an indication that the malpractice crisis is not yet over.

The KMS leadership has protested the proposed increases at the Insurance Commissioner's office, and urged insurance companies to hold the line on premiums. Every available option is being evaluated and a full discussion of the issue will be presented at the January Council meeting. We will keep the membership informed on developments through the newsletter and special mailings. If you have any question about your insurance coverage, please call the KMS office at 1-800-332-0156, or the Insurance Commissioner's office at 913-296-3071.

Following complaints from physicians about its recently published assistant at surgery denial list, the Blue Shield Medical Advisory Committee reconsidered several procedures and changed its position to allow assistant surgery fees for the following procedure codes: 23420, 23470, 27234, 27244, 27822, 20250, 20251, 27537, 27580, 27705, 29882, and 29887.

Other procedures were considered but not changed because most procedures were conducted without an assistant surgeon. Blue Shield may make allowances for assistant surgery fees if individual consideration is requested and the use of the assistant is medically necessary. This decision will be reported in a future newsletter.

In This Issue...

- Malpractice update
- Assistant surgery codes reconsidered
- Medicaid: Place-of-service codes
- Medicaid 10% cut in range max
- KMS dues payment schedule
- DRGs for MDs?
- Communication: Listen more
- Project USA seeks MDs
- HMO Kansas chart reviews
- OBRA challenge--your help needed!
- Booklets available
- Medical records: Ownership

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QUESTIONS RE: MEDICAID
REIMBURSEMENT?

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1-800-232-0054 is the toll-free WATS line for providers of services under Medicaid. It is the EDS Federal (Electronic Data Systems Corporation) that administers the fiscal part of the Medicaid program.

EDS reports that much confusion still persists with listing the place-of-service codes when filing Medicaid claims. The requirements for listing these codes became effective last October when Medicaid mandated the explicit use of HCFA-1500 claim forms. The place-of-service (POS) codes are listed on the back of the new HCFA-1500 form. They are as follows:

- | | |
|-------------------------|--------------------------------|
| 1 - Inpatient Hospital | 8 - Skilled Nursing Facility |
| 2 - Outpatient Hospital | 9 - Ambulance |
| 3 - Office | 0 - Other Locations |
| 4 - Home | A - Independent Laboratory |
| 7 - Nursing Home | B - Ambulatory Surgical Center |

While the old claim forms will be accepted as long as your existing supply lasts, it will speed up the processing of your claim if the POS codes listed above are utilized.

MEDICAID BUDGET CUTS

In response to the announcement of a 10% cut in reimbursement for the balance of the current state fiscal year, the Kansas Medical Society submitted to SRS a strongly worded objection that said in part,

Kansas physicians always have, and will continue in the future to do their part for the indigent of this state and the Kansas Medicaid program. With the exception of some office and outpatient procedures, Kansas physicians currently are paid on the basis of 1975 fees, and in many cases, receive less than 50% of their billed charges for taking care of Medicaid patients. During the last several years we have cooperated with the Department fully in implementing many programs which have saved the state money, yet which maintained the objective of keeping physicians in the program in large numbers. Physicians want to do their part during the tough economic times which face our state; however, we believe they will have to absorb a disproportionate share of the spending reductions under your current proposal. We urge you to reconsider the fairness of the proposed cuts and pledge our continued willingness to work with you to achieve the necessary savings mandated by Governor-elect Hayden's order.

SRS proposes to slice the 10% off the range maximums. This means that those physicians whose charges are less than the range maximum will experience no cut or a cut of less than 10%, unless this situation is reversed in the Legislature.

INSTALLMENT DUES
PAYMENT SCHEDULE

To take advantage of the newly initiated installment payment for your KMS and AMA dues, use the following schedule:

KMS dues: \$220.00 by 2-1-87
AMA dues: \$337.50 by 4-1-87

DRGs FOR PHYSICIAN SERVICES

Reagan's draft budget for the next fiscal year, which had recommended implementation of the DRG concept for physician/hospital reimbursement for services provided to Medicare patients, has been modified to apply only to services of radiologists, anesthesiologists, and pathologists. The proposal would require that payments to hospitals and physicians who provide these services be made in one lump sum per case at a predetermined fixed rate, based on diagnosis, without regard for length of hospitalization, number of services required, or number of physicians involved.

According to budget documents, Medicare would pay the hospital, and the hospital would then divide the money, unless the hospital's medical staff had negotiated a "formal agreement" to provide for direct payment to physicians. States would receive a bonus from the federal government if they paid a standard amount, set in advance, for each Medicaid beneficiary, rather than paying a separate fee for each service.

A budget official was quoted as saying that payments to physicians were "out of control" because they rose an average of 15% a year from 1980 through 1985.

A lobbyist for the American Association of Retired Persons, an organization with more than 23 million members, said that the new proposal "could simplify matters for beneficiaries" by reducing the number of bills they received following hospitalization.

There is strong opposition to the proposal from the AMA; Dr. Otis R. Bowen, Secretary of Health & Human Services; and Dr. William L. Roper, head of HCFA, which directs Medicare. Aides to Secretary Bowen said he would urge Reagan to eliminate the proposal before the budget is submitted to Congress in January.

FOCUS ON COMMUNICATION

"There's more to doctor-patient communication than words; there has to be rapport. Physicians must be good listeners, maintain a positive regard for the patient and make sure the patient's agenda receives equal importance."

These remarks were made by Charles Driscoll, M.D., at a recent joint leadership conference sponsored by the Iowa Medical Society and its Auxiliary. Dr. Driscoll, Associate Professor and Acting Head, Dept. of Family Practice, University of Iowa College of Medicine, further noted that a recent study revealed that physicians talk 91% of the time.

PROJECT USA SEEKS SHORT-TERM PHYSICIAN SERVICES

Project USA is an AMA program to recruit fully licensed physicians for short-term, general medicine assignments at Indian Health Service (IHS) and National Service Corps (NHSC) hospitals and clinics. Vacancies are two to four weeks and physicians are paid \$750/week at IHS and \$500/week at NHSC clinics. For additional information, contact John Naughton, Project Director, at the AMA, 535 No. Dearborn, Chicago IL 60610; or call 312-645-4702.

REVIEW OF HMO KANSAS PATIENT CHARTS

Richard Beach, M.D., HMO Kansas Medical Director, reports that a Blue Shield task force has been studying the issue of in-office review of HMO Kansas patient charts and recommendations are in the formative stage. Criteria are based on those currently used by the American Academy of Family Physicians.

The program would consist of onsite review of four charts for each of nine different diagnostic codes. The physician would then receive an evaluation of his/her compliancy rate with accepted standards. If acceptable, the physician would be so notified; if unacceptable, suggestions for change would be made. If unacceptable patterns continue, further action--as yet undefined--would be taken.

The national Blues hope to have 50 plans implement the program by early 1987, but it isn't known if HMO Kansas will be in the initial group.

The program is being developed primarily to monitor the type of care being given. Statistics can be generated to show employers and the government the effectiveness of care given in the HMO. HMO contracts with physicians and patients already include provisions for in-office review of charts.

AMA TO CHALLENGE OBRA: YOUR HELP IS NEEDED!

The AMA plans to challenge the Omnibus Budget Reconciliation Act of 1986 in the courts. The suit will argue that OBRA is unconstitutional under the equal protection and due process clauses of the U.S. Constitution. To substantiate this challenge, it is essential to present proof of the failure of Medicare carriers to provide physicians with the data necessary to make an informed decision on participation and to comply with the MAAC provisions. For information on how you can help, call the AMA's Office of General Counsel (312-645-4615) or the Division of Legislative Activities (312-645-4770).

BOOKLETS AVAILABLE

A series of booklets entitled What Every Physician's Spouse Should Know is available from the AMA Auxiliary. It features booklets on professional liability, impairment, survival tips for resident physician and medical student spouses, medical marriages, and retirement and estate planning. Each booklet costs \$5, or \$3 for AMA Auxiliary members. Send prepaid orders to: AMA Auxiliary, 535 N. Dearborn St., Chicago IL 60610.

OWNERSHIP OF MEDICAL RECORDS

Wayne T. Stratton, J.D., KMS legal counsel, has advised that the weight of legal authority is that the physical record itself belongs to the physician; however, the patient has a proprietary interest in the information contained therein and therefore the right to obtain copies of such records.

Stratton notes that he believes it to be understood that under certain circumstances when release of information may be harmful to the patients, there may be exceptions to the general rule. The overwhelming consideration in any case is the welfare of the patient.

Radiology: Radiology services should be under the direction of a board certified radiologist with special competence in maternal and pediatric radiology.

Respiratory Therapy: The registered respiratory therapist is accountable for administering all types of routine and special respiratory therapy, including the use of medical gases, drugs, and life-support equipment. The duties of the registered therapist require him/her to be a graduate of an accredited school of respiratory therapy, pass the national written examination, and the National Clinical Simulation examination.

Occupational and Physical Therapy: These services should be available through referral to provide support related to developmental problems of the neonate during hospitalization, discharge planning, and post discharge.

Social Work: Each social worker in the obstetric and neonatal areas should have a Master's Degree in Social Work from a school accredited by the Council on Social Work Education. The perinatal social worker must be skilled in individual, family, and group counseling and the use of local, state, and federal resources to maximize the family's adjustment to the pregnancy and infant.

Nutrition: The dietitian/nutritionist must meet the requirements for membership and registration in the American Dietetic Association and have at least one year of hospital clinical experience; graduate nutrition education that includes advanced courses in pediatric and/or maternal nutrition, physiology, biochemistry, and statistics; and advanced clinical pediatric training or clinical experience in the nutritional care of critically ill newborns, women, and infants with complex medical and surgical problems. A Master's Degree is highly desirable as well as specialized training through perinatal-pediatric fellowships sponsored by Title V/MCH.

Additional Support Staff: Family support is essential to the favorable outcome of perinatal patients. The needs of the patients and family require the expertise of individuals with special training and sensitivity to these needs. Individuals with special interest and expertise may be designated to fill this role. These team members often include a variety of disciplines such as chaplains, genetic associates, psychologists, public health nurses, and others.

Nutrition Services

Level III nutrition services should include comprehensive outpatient and inpatient care for normal and high-risk maternal and neonatal/pediatric pa-

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tients, including those with medical and surgical complications. Service components include screening for nutrition problems, assessing and monitoring nutritional status, developing and implementing nutrition care plans, providing resources for special dietary modifications, and providing maternal and neonatal/pediatric outpatient followup. The implementation of the nutrition care plan will require integration with the overall plan of care, and coordination with and referral to local agencies/providers of food assistance and nutrition care services.

Additional elements of this service are consultation with Level I and II Centers; in-service and outreach nutrition education for health professionals, community outreach education, and monitoring and evaluation of nutrition intervention services.

Social Services

Social work services are an integral part of the perinatal team approach. These services must be available for both normal and high-risk patients during the prenatal, intrapartum, postpartum, and neonatal periods including pre/post hospitalization. They should assist the family in adjusting to the pregnancy, maximize the family's potential for optimal

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growth and development, and identify situations that indicate risk for psychosocial problems and complications during pregnancy, delivery, and/or post delivery. These services should seek to alleviate the stress that accompanies high-risk pregnancies by educating families about the nature of their circumstances, participating in discharge planning, and establishing supportive networks in the community for followup services.

Discharge Planning, Referral, Followup

Every Level III Perinatal Center should have a comprehensive discharge planning program, addressing both the general and specific needs of each infant, mother, and family. This program's protocols should be reviewed and updated by an active discharge planning committee under the direction of a health professional with experience in discharge planning, home care of the high-risk infant and/or mother, and necessary followup. Staff members responsible for dismissal instructions and preparations should be aware of or consult with a person knowledgeable of community resources and be responsible for making appropriate referrals. It is the responsibility of the nursing, nutrition, and social work

staff, in cooperation with the physician(s), to organize the followup program for each mother and/or infant.

Discharge summary and plan for followup should be forwarded to the local physician.

The perinatal center should implement a neonatal followup program — such as a high-risk followup clinic — to screen for developmental delays and physiological problems for infants who received care in the center's neonatal intensive care unit or were identified to be at risk. The followup team or clinic staff should involve a neonatologist, nurse, social worker, and developmental specialists (*e.g.* OT and PT). Access to nutrition services should also be available. Followup evaluation and recommendations should be communicated to the infant's local physician who should coordinate the infant's care with the family. Participation in the statewide Early Identification and Intervention Project is expected of all Level III Centers.

Followup strategies should also be planned for the high-risk maternal client to assure the mother's compliance with discharge instructions and contact made with local private and public health services appropriate to the mother's needs.



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Professional Staff Education & Outreach

The major function of a statewide perinatal program is the provision of preparatory and continuing education to promote the delivery of quality perinatal health services. The quality of perinatal services should not be based solely on the availability of electronic equipment, facilities, or transport systems. The critical factor is personnel, educated and experienced in the best professional techniques of perinatal care, working within a coordinated regional system.

The Level III Center has the responsibility for planning and providing education services in their region. Commitment to this responsibility can be demonstrated by (a) providing consultation to Level I and II Centers and physicians in the region; (b) providing education coordination; and (c) providing outreach education programs.

In addition to in-house residency training programs for pediatrics and obstetrics, the Level III Center should make available in-service for all members of the perinatal team. Educational methods should include, at a minimum, didactic symposiums, written guidance materials and protocols, conferences and lectures, practicums/minifellowships, courses with academic credit and local, regional, or statewide perinatal conferences.

Evaluation & Research

Level III Perinatal Centers should evaluate perinatal data on a regular basis by utilizing a formal perinatal review committee. Precise definitions and a process for evaluation of perinatal care is needed to ensure a uniform system of reporting.

A variety of sources can provide the appropriate data, such as the Perinatal Center's perinatal casualty statistics, chart audit, and data from followup postpartums and pediatric clinics.

Research should be actively pursued at the Level III Center. This research will assure the development of state-of-the-art concepts in perinatal care. Participation in national and international conferences related to the center's research activities will promote the expansion of perinatal medicine.

Summary

These Guidelines for Level III Perinatal Centers in Kansas were developed from a variety of national and state resources. A Level III Perinatal Center is a regional facility that provides normal and high-risk obstetrical and newborn care for patients in its immediate vicinity as well as support for Level I and II Perinatal Centers within its region. Services

within these centers include all facets of perinatal medicine beginning with conception planning, prenatal, intrapartum, newborn, postpartum, and the direct care and followup for the mother, newborn, and family. The priority of high standards in patient care requires the interaction and contribution of many disciplines within the health care system, both within and outside the hospital, and between public and private health care sectors.

Each Level III Perinatal Center is obligated to serve patients and health care providers by (a) providing the services and assuring access to the perinatal team(s) described in these guidelines; (b) implementing a self-evaluation and research process; (c) offering varied educational opportunities; and (d) participating in activities and programs conducted by public and private institutions and agencies that address perinatal care. The goal of each perinatal center is to provide quality perinatal care for the childbearing patient, infant, and family.



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SPECIAL FEATURE

Men of Their Time

DAVID E. GRAY, M.D., *Topeka*

THEY HAD MUCH in common. Close in age, they all had New England origins and education. Anti-slavery sentiments brought them to Kansas at the same time. Politics attracted them — or was thrust upon them — leading to their election to the three highest offices in the first administration of the new state. And they were legitimate physicians as well as incorporators of the Kansas Medical Society. But Charles Robinson, J. P. Root, and John W. Robinson (see cover) were diverse in nature as their subsequent lives testified.

The most controversial of these would have to be Charles Robinson whom fate led to Kansas by a circuitous path. If there is more biographical material about him than the others, it sometimes complicates rather than clarifies. After education at Amherst, he studied medicine by preceptor and lecture and was graduated in 1843 from Berkshire Medical School. But his medical career in his native Massachusetts left no account of outstanding accomplishments. He married Sarah Adams in 1843, but by 1846 had lost her and two infant children to death.

This loss of his family undoubtedly played a part in inducing him to join a group of New Englanders on a gold-seeking trek to California in 1849. His mining experience lasted only two weeks, but his observations of that territory produced in him a great interest in settlers' (read squatters') rights. He quickly became a leader in that cause which led to editorship of a paper supporting them, a term in the California legislature, as well as a stay in prison (the indictment was quashed) — and even, at one point, proprietorship of a restaurant.

He returned to Massachusetts in 1851 and within a month married a young woman with whom he had corresponded earlier. She was Sara Lawrence (the city of that name was a tribute to Amos Lawrence, a relative of Sara and close associate of Charles in years to come). They became strongly involved in the abolitionist movement and in the establishment of the New England Emigrant (later the Emigrant Aid) Society. Charles and Amos were

the first to lead parties to Kansas to help settle it as a free state. His involvement in starting first the territory, then the state, led to his election as governor of each in turn and to the firming up of the Republican Party and its role in the coming years (although the internal frictions in that party would produce more political upheaval within it than usually exists between two distinct parties).

But it is necessary to consider at this point another actor in the early Kansas political and medical scenes, J. W. Robinson (no relation to Charles). He was born in Maine and graduated from Bowdoin Medical College in Brunswick, Maine. He spent some time at Massachusetts General Hospital, then settled in Hallowell, Maine where he was physician to the City Hospital as well as Thomaston State Prison. It was in 1857 that he and his wife came to Kansas (for his health) and he became involved in the affairs of that territory. He practiced in Manhattan, but became enough involved in politics to be nominated for the office of Secretary of State on the Republican ticket in the first state election, winning his office along with Charles Robinson as Governor and J. P. Root as Lieutenant Governor.

The new state had no money, so one of the first orders of business was to sell some bonds, a task assigned to John Robinson and George S. Hillyer, State Auditor. Eastern financiers were not, however, falling over themselves to buy the bonds of the new state. There were numerous efforts which multiplied the plans and inducements. Eventually, with the help of R. S. Stevens, a business friend of Charles Robinson, a chance appeared to sell one group at 60 cents on the dollar and was accepted by them. Whether or not they knew that Stevens, all the time, had another deal to sell them at 85 cents (which he did), this served as the basis of the charges of fraud later brought against the Robinsons and Hillyer.

All this played into the hands of Senator James Lane, long a bitter political opponent of Charles, and he made the most of it. Where the others (Charles, John, and Root) were abolitionists, Lane

was a "Free Stater" — but his idea was to create this by allowing *no* blacks, free or otherwise, in the state and, at one point at least, was not averse to lynching to assure that condition. He, as one of the first pair of senators from Kansas, was well established in Washington, ingratiating himself with Secretary of War Stanton and, through him, President Lincoln — although there is no indication that Lincoln was aware of the things done in his name. Lane's acquisition of military patronage in the state was a strong weapon at home and he was determined to cause Governor Robinson trouble with it as well as with other weapons that came along.

However astute he was in political matters and dedicated to admirable principles, Charles apparently could not warm to people and establish the political security he would need against an enemy of Lane's type. Thus, in 1862, with the revelation of the bond sale (of which John and Hillyer were initially proud as they later disclaimed any knowledge or intention of fraud), articles of impeachment were brought against both Robinsons and Hillyer. John was tried on eight counts, being acquitted of all but one — that the sale was carried out with his knowledge and consent. That, of course, was enough and he was removed from office. Hillyer's experience was the same. Charles Robinson was, in turn, tried on five counts and acquitted of all.

After the trial, Governor Robinson arranged for John to get a commission as a medical officer in the army, perhaps not very difficult since the army was looking for them. John died at Fort Smith, Arkansas, December 10, 1863. It has been reported, although not documented, that he died of a broken heart. As one reads the history of those tumultuous times — and if one is inclined to grant him some charity in interpreting his role — that is not too remote a possibility.

Despite being cleared of the charges, Governor Robinson failed to retain the political strength he had known, although he continued a steady presence on the political scene. Liberal views would cause Charles Robinson to break with the conservatives in the Republican Party, to align himself with the Independent Reform Party — Republicans of a more liberal bent than the bulk of that party. Later he would be identified with the Populists. The connecting link in all of his efforts was a primary concern with individual rights. Although a temperance supporter, he fought prohibition as unenforceable. He worked for financial reform (including the printing of more paper money), women's rights, and Negro and Indian rights, particularly as to education.

He was a prime mover in getting a state university established (and in Lawrence). He became superintendent of Haskell Institute, making several trips to Indian Territory to encourage matriculation by the young people, and he more than doubled the enrollment. He was instrumental in the formation of the Board of Regents, of which he was a member from its inception until 1894, when he cited health as a reason for retirement, although it was more a matter of thinking some of the policies wrong and feeling unable to change them. He did, however, die in 1894, still with friends and still with enemies — and with a still-felt effect on Kansas today.

J. P. Root was the one of the triumvirate who remained closest to medicine, although he was no stranger to politics. Born and educated in Massachusetts (his medical degree also was from Berkshire Medical College), he practiced in Hartford, Connecticut, and served in the Connecticut legislature before coming to Kansas in 1858. He became a member of the Territorial Senate, then with the adoption of the Wyandotte Constitution, lieutenant governor of the territory, moving on to that office in the state with the first state election.

He managed to avoid the political difficulties of his colleagues. With the chartering of the Kansas Medical Society in 1859, Dr. S. B. Prentiss was elected the first president. The first meeting was devoted to establishing rules, election of officers, and arranging for the next meeting. Dr. Root took office as KMS President in 1860, but the arrival of the Civil War brought a halt in meetings until 1866 when he again presided. He served as Surgeon to the 2d Kansas Cavalry and returned at the war's end to practice at Wyandotte. He continued to be active in the Society, holding various committee assignments. In 1870, President Grant appointed him Minister Plenipotentiary to Chile where he was reported to be instrumental in controlling a smallpox epidemic and was awarded an honorary degree from the Medical University of Santiago. He returned to Wyandotte in 1873, but soon moved to Clifton Springs, New York, and did not return to Kansas, serving in Clifton Springs at a sanitarium. He died in 1885.

In all, Governor Charles Robinson, M.D., Lieutenant Governor Joseph Root, M.D., and Secretary of State John W. Robinson, M.D., were alike — and very different. They had moments of nobility and of pettiness. Their strengths and weaknesses, their successes and failures are embodied in the state they helped to form.

A bibliography is available from the KMS office.



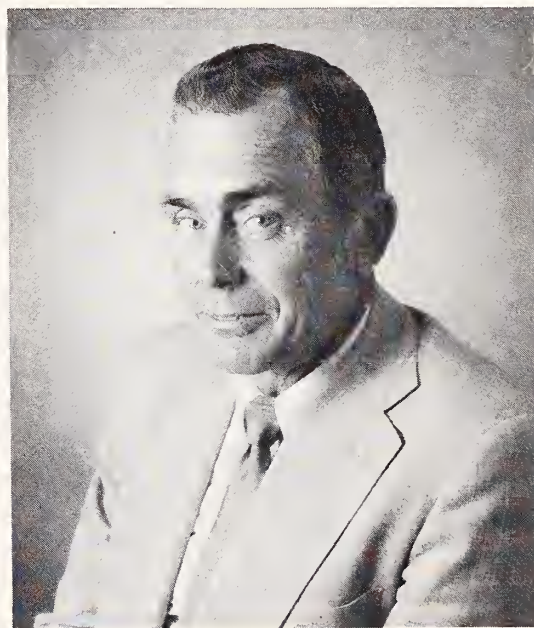
PRESIDENT'S MESSAGE

Now that the holidays are behind us, the football season is waning, and the Christmas bills are beginning to arrive, it's also time to think about and concentrate on the 1987 legislative session. As noted previously, this past year was a successful one from the legislative standpoint, but much work remains to be done.

A ruling on collateral source is due shortly after mid-January. The constitutionality of HB-2661 is being challenged in the courts, but will not be resolved for some time. There are housekeeping chores relative to HB-2661 that need to be addressed early in the legislative session, especially with regard to reporting procedures.

In spite of last year's tort reform legislation, medical malpractice premium costs for Kansas physicians continue as an ever-increasing problem, and the Kansas Medical Society will explore all options to seek an effective solution.

All of the above emphasizes the necessity to renew and maintain our legislative contacts. At present, there is no national legislation to address our difficulties, which means that relief must be sought at the state level. I urge you to call or write your legislators and inform them of your concerns. Kan-



sas physicians were a significant force in this past year's elections, and we need to persist in applying and directing that force.

Best wishes for a successful 1987.

F. S. Bickelmeier MD

President



EDITORIAL COMMENT

Reaction to Accommodation

IF PERPETUAL motion has been deemed scientifically impossible, perpetual collision is not only possible but ever present. The prime example is the continuing contention between medical progress and the price it exacts to be accomplished.

In theory, the former should return to society enough benefit socially and economically to justify the latter. In practice, this is at best problematic, although the long view persistently hopes for success — or a shift in social values to make it justifiable. Just the accomplishments of the last half-century have brought limited survival gains, promoted new avenues of intellectual effort, established new industries, thrown the ethicists into an uproar, forever changed medical service — and run up a staggering bill even as they promise much for the future.

Time was that illness, surgical or otherwise, was a private matter unless the patient was of more than average note to the world. Now it is the procedure that is of note, and hardly any is unworthy of report. Cameras record the intricacies of the patient's management, and press conferences follow the patient's course — or lack of it. Procedures that once were confidential because they were unusual as well as new, scarcely tried (by old standards) procedures are attended by publicity that extends far beyond the patient. The casual viewer, if aware of the enormous price, assumes some means — insurance, philanthropy, sacrifice of remuneration by the performers or the government — will meet it. And the bedside notes become the latest news bulletins.

So, interwoven in this complex is the essential necessity to consider its cost with its many factors and the reconciliation of society's expenditure with the economic benefit with the return to whatever degree of productivity. Not the least of the relative concerns is the growing belief that human life and health warrant their availability to all concerned and the fact that a large segment of that populace must rely on some public funds to meet virtually all medical service, however devious the path taken to bring the funds to the case.

Those charged with developing public policy or dispensing public funds view such matters in the

broad sense, however skewed by special individual cases. Physicians with their traditional conditioning look at it in terms of the individual patient, with public economic limitations forming an unwanted professional restriction. The two attitudes meet ultimately on the ground of patient care and must reach their conclusions with full respect to the individual, the medical servitors and the public, whether directly or indirectly involved. Too often the meeting ground becomes a battleground at a time when each side needs the other to meet the joint responsibilities.

In attempting to narrow the matter to some critical point, one faces the unpleasant fact that public monies are finite. And for every patient who warrants some dramatic surgery or esoteric therapy, there are untold numbers who have more commonplace problems, unworthy of special public interest (including emotional media appeals) or attention beyond the patient's immediate sphere. But one is reminded that there are no "ordinary" afflictions to the afflicted.

The phenomenon, then, has other aspects. For one, there is public pressure on research and treatment facilities to hurry on with their work — not only to extend the application but to make it more economical. But this leads to a demand that money be thrown at every problem. This concept extends far beyond the medical area since it is so often government money that is demanded.

Administrators of public funds know the impossibility of meeting, even determining, the relative needs. Physicians are a natural source of consultation in the effort but must take a concerned if realistic role in their recommendations. How many immunizations, how much nutritional support or prenatal service, how much nursing care can be accomplished for the same public funds expended in a complicated transplant case?

Inevitably — and increasingly — the role of the physician and the substance of the profession will be altered by the necessity to reconcile medical propriety with economic possibility. — *D.E.G.*



Drug Dispensing

WAYNE T. STRATTON, J.D., *Topeka*

IT IS RARE that a physician's office does not display at least one calendar and several pads of memo paper bearing the name of a particular pharmaceutical company or drug. Physicians are virtually inundated with pharmaceutical advertising, including medication samples and offers to fully supply the physicians' pharmaceutical needs. While sample medications do have their benefits, and while the ability to dispense pharmaceuticals directly to the patient does have certain advantages, the physician must recognize that the distribution and sale of drugs is rigidly governed by state and federal laws. Practitioners must also realize that the potential for increased civil liability also exists when they become drug dispensers.

While handing out sample medications may be a good way for the physician to test a particular drug's efficacy for a patient without forcing the patient to spend money for a large dosage which may be changed later, the physician must exercise caution in dispensing samples. Under Kansas law, it appears that no additional registration and licensure steps are necessary for a physician to give a sample drug; however, there may be additional liability implications. These implications appear to mimic the implications for dispensing physicians discussed below. Even though the amount of the drug stored and dispensed is smaller, the same precautions must be taken in the care of the samples as those taken by the dispensing physician.

* KMS Legal Counsel

Editor's Note: This is the 15th in a series of regular columns concerning current subjects of legal interest to physicians. For the sake of brevity and clarity, citations and footnotes are omitted.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE or the Kansas Medical Society. For further information, contact Mr. Stratton, 215 E. 8th, Topeka, KS 66603; 1-800-332-0248.



Kansas law provides that a duly licensed physician may purchase and keep drugs, may compound prescriptions, and may administer, supply, and dispense drugs to patients subject to inspection by the proper authorities and compliance with the Kansas Uniform Controlled Substance Act, the Kansas Pharmacy Act, the Kansas Food, Drug and Cosmetic Act, and federal drug enforcement laws. Under Kansas law, a physician who purchases and keeps drugs and compounds his own prescriptions for his patients is a dispensing physician. Physicians should also be aware of applicable Medicare and Medicaid statutes.

Dispensing physicians must clearly label each drug dispensed with the patient's name, an identification number assigned to the prescription order, the date, adequate directions for use, and expiration date of the drug dispensed. The brand name or corresponding generic name and manufacturer or distributor's name and the strength dispensed shall be included at the discretion of the physician. All medications dispensed by a physician must be placed in child

(Continued on page 31)



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A PERSONAL VIEW

In Search of a Health Care System for Farmers

DONALD D. GOERING, M.D., *Coldwater*

I WAS RAISED on a farm in McPherson County. I recall the dust bowl days, but also the satisfaction my father had in paying off the mortgage on the family farm. My brother — the youngest of the boys — still farms that land homesteaded by my grandfather in the late 1870s.

Initially I practiced in Tribune in Greeley County for 4½ years, then in solo practice in Salina for ten years as a family physician. Three years in group practice showed me it was not for me, and for nearly eight years, I have been in solo family practice in Coldwater in Comanche County.

These credentials permit me to say there *is* a farm crisis. I — and any resident of the area — know too many cases to doubt it. The individual tragedies are measured in older people who find their resources, their retirement plans, gone. Young farmers, overextended in the effort to get started, are caught in uncontrollable economic stresses with dissolution of individuals and families. Young people, seeing no future in farming, turn to other pursuits, and even these — if related to farming or in farming communities — are at risk of going under, so many go elsewhere.

Medical care is threatened. The Blue policies through the Farm Bureau went to a \$1,000 deductible plan which some can't afford. These people are living with their chronic problems — even acute ones — and the stresses they produce as well as the associated economic problems. Most physicians are familiar with cases of depression, suicide, alcoholism, and other serious medical problems.

Now many farm families, lacking insurance of any kind, wait longer for medical care. Any measures of preventive medicine are displaced by an episodic crisis type of medical attention. To many physicians, the concept of continuous, comprehensive health care for families is a simple and major principle. Not so in our rural communities.

There is a challenge here for the medical community — but challenges are not new to physicians. The care of the poor has always been a challenge. In 1961 when I started in practice, welfare patients were seen in the office at no charge, shots were \$1.00, surgery and obstetrics were half-price — and the bill was paid at the local level by the welfare department, apparently to general satisfaction. But then the Kerr-Mills Bill established that these patients were consequently second class citizens and should have their own physicians at the usual and customary fees. It was a fine concept — but the money soon ran out. Some physicians were forced to reduce their "usual and customary" fees to the point of stopping seeing such patients. Others must accept half to two-thirds of their fees (a new definition of second class citizens?) as bureaucracy replaced the simplicity of handling on the local level.

It seems to me that the rural poor are different. Some have border-line incomes that disqualify them for welfare. Most are too proud to accept it. All they want is a chance to work and make their own way. In this regard, the status of farm laborers is similar to that of oil field workers, for example, who are experiencing economic stresses that are affecting health problems. When such groups are so affected, it permeates the whole community.

Such problems bring the inevitable question: is there a solution? There are always solutions. Some see the answer in extreme right-wing organizations such as the Posse Comitatus, a frightening one to most. But there are other ways, and one of the most prominent is a cry for more federal or state aid. At

These comments were condensed from a talk given by Dr. Goering at the KMS-KHA conference, *The Farm Crisis: New Challenges in Health Care Delivery*.

Editor's Note: The opinions expressed in "A Personal View" are that — personal views of individual KMS members. KANSAS MEDICINE welcomes such expressions of opinion and denies any legal responsibility for their content.

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a time of deficits and similar problems at those levels, I don't feel their resources make a viable solution today.

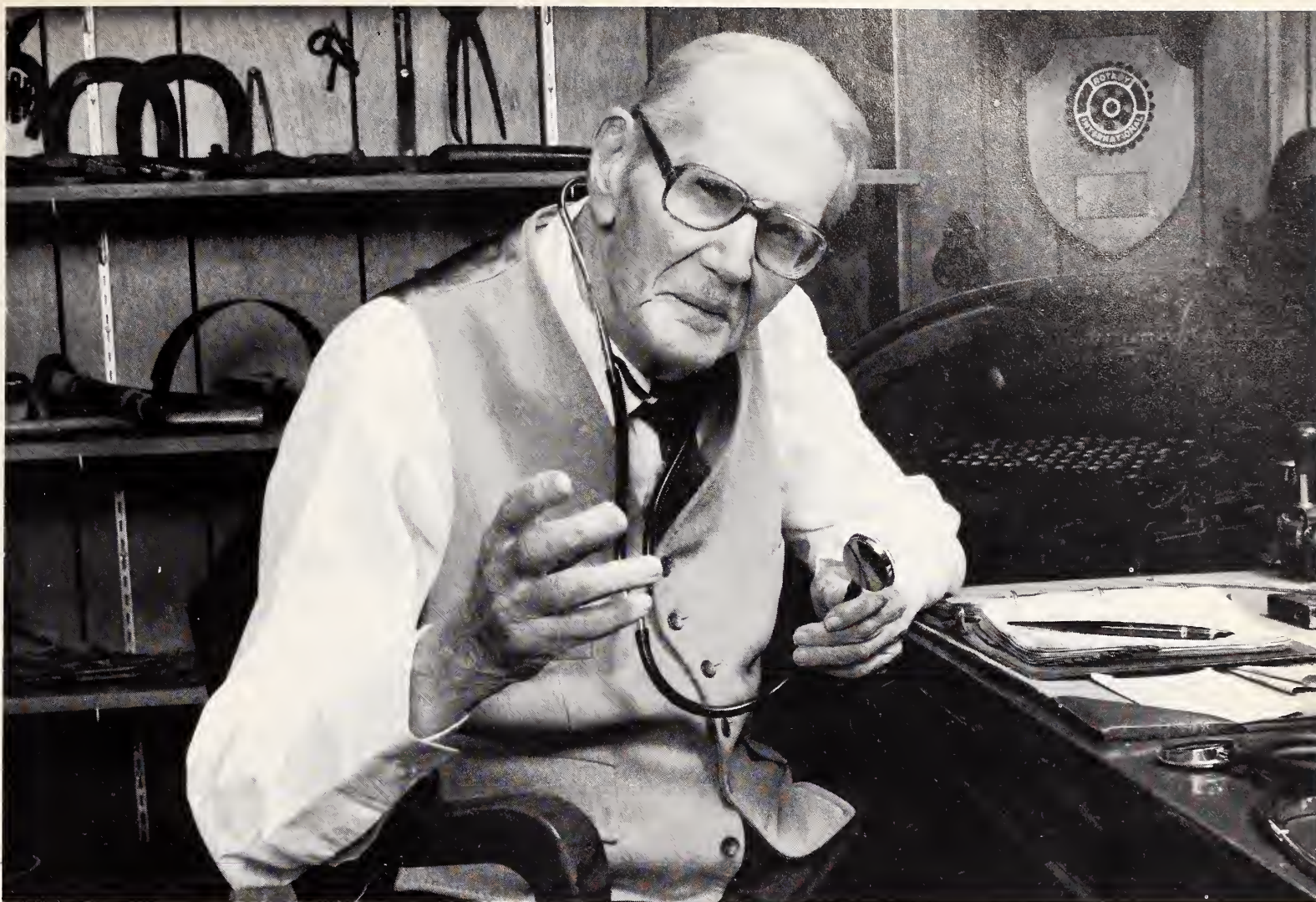
Is the answer a state-wide program, perhaps a state HMO? Any citizen could sign up, pay a set fee to belong, and be assured of care, the only problem being to determine what that fee would be. Early in my career, I thought such a plan might be ideal — I could practice without worrying about whether a patient could pay me or not. But I have learned that any plan that is all-inclusive, both for procedures and patients, is difficult to maintain, as we have seen in the example of the Medicare program. Acquaintances who practice privately and partly in HMOs tell me that HMO patients do receive less medical care — it is cheaper because they get less.

Should nurses serve as primary care attendants, passing the complication on to physicians? I worked for one year (1957) in the jungles of South Vietnam where the lack of doctors meant that nurses with six weeks' training used a "cookbook" type of care according to symptoms from a protocol. Many patients never saw a doctor during their entire lives. In 1973, I spent a month at a medical missionary

hospital in Zaire where they, of the same necessities, followed the same plan. In this country, the counterpart is becoming the county health department where in some instances nurses do kindergarten physicals, give immunizations (which, with the increased cost of biologicals, they can do much more cheaply than I can), conduct a myriad of clinics including diabetes, pap smear, birth control, well-baby, and VD clinics as well as other laboratory tests, health fairs, and so on. The result, of course, is that many people — especially those of borderline income — are coming to see the health department as their primary source of care. Is that too different from those under-developed countries? Is that the solution we want?

Perhaps at the local level we could develop a program such as that in Marshalltown, Iowa where two clergy people were instrumental in the establishment of the Farmers' Medical Emergency Program. The Community Resource Committee of the County Extension Service runs it with eligibility guidelines established for farmers who apply on the basis of medical need. The local level and the Extension Service processing are particularly appealing.

(Continued on page 30)



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Personal View

(Continued from page 28)

ing as opposed to a medical or welfare organization. Cooperation among all the involved individuals seems to be working.

I don't pretend to have the answers — what to do or how to do it — but suggest that we not throw away the best medical care system in the world to do it. Most physicians are doing what they have always done: rendering the best possible care at the least possible expense to the greatest possible number of people in the best way we can — reducing rates if necessary, providing free care if payment is impossible, being lenient with credit.

Patients can verbalize their hostilities and emotional problems, helping us to do what we are trained to do best — render *personal* medical care to the best of our abilities. I for one, and most doctors agree, will continue to do this regardless of what the final structure of our medical care system becomes.



Happy New Year!



Drug Dispensing

(Continued from page 25)

resistant containers as required by law, and in light resistant, air-tight containers as required by federal law.

Dispensing physicians must keep a file of all prescription orders and make this file available to state and federal inspectors. Files must be maintained for at least three years. The physician must also maintain inventories and records of all controlled substances in the manner prescribed by state regulation. Inventories of all controlled substances must be made initially and then every two years on May 1. The records of these inventories must be maintained for a minimum of three years.

Finally, dispensing physicians are responsible for the security of all the drugs they maintain. Physicians are mandated to provide efficient controls and procedures to guard against theft and diversion of controlled substances, and all drugs must be stored under conditions proper and suitable to maintain the drug's integrity.

The failure to comply with federal and state laws relating to the dispensing of prescription drugs may result in criminal liability or revocation of licensure. Additionally, the physician who dispenses drugs may incur additional civil liability. The primary standard used to determine the liability of a dispensing physician for a drug related adverse complication is the standard of care for a similar physician in similar circumstances. However, liability may also accrue for failure to properly store the drug, thus changing its efficacy, for failure to remove unfit or postdated drugs, or for improper storage that causes an inadvertent substitution of one drug for another.

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KANSAS MEDICINE will print a maximum of ten **references**. All applicable references should be marked by superscripts in the text in the order cited. If more than ten sources are cited, the author should designate the ten most significant to be printed, and readers will be referred to the author for the complete list.

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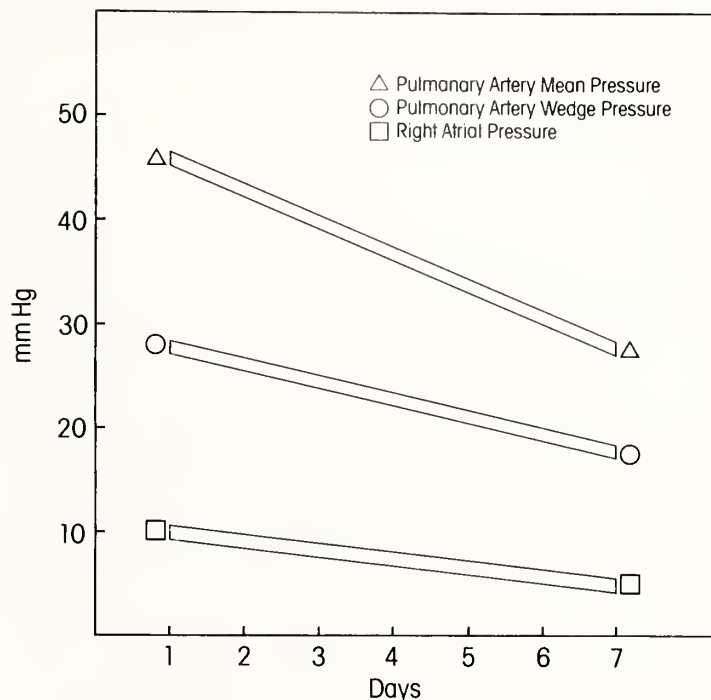
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INDICATIONS AND USAGE: Edema associated with congestive heart failure, hepatic and renal disease, including the nephrotic syndrome.

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CONTRAINDICATIONS: Anuria. Hypersensitivity and in patients in hepatic coma or in states of severe electrolyte depletion. Although Bumex can be used to induce diuresis in renal insufficiency, any marked increase in blood urea nitrogen or creatinine, or the development of oliguria during therapy of patients with progressive renal disease, is an indication for discontinuation of treatment.

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Prevention of hypokalemia requires particular attention in patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis and ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, certain diarrheal states, or other states where hypokalemia is thought to represent particular added risks to the patients.

In patients with hepatic cirrhosis and ascites, sudden alterations of electrolyte balance may precipitate hepatic encephalopathy and coma. Treatment in such patients is best initiated in the hospital with small doses and careful monitoring of the patient's clinical status and electrolyte balance. Supplemental potassium and/or spironolactone may prevent hypokalemia and metabolic alkalosis in these patients.

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PRECAUTIONS: Measure serum potassium periodically and add potassium supplements or potassium-sparing diuretics, if necessary. Periodic determinations of other electrolytes are advised in patients treated with high doses or for prolonged periods, particularly in those on low salt diets. Hyperuricemia may occur. Reversible elevations of the BUN and creatinine may occur, especially with dehydration and in patients with renal insufficiency. Bumex may increase urinary calcium excretion.

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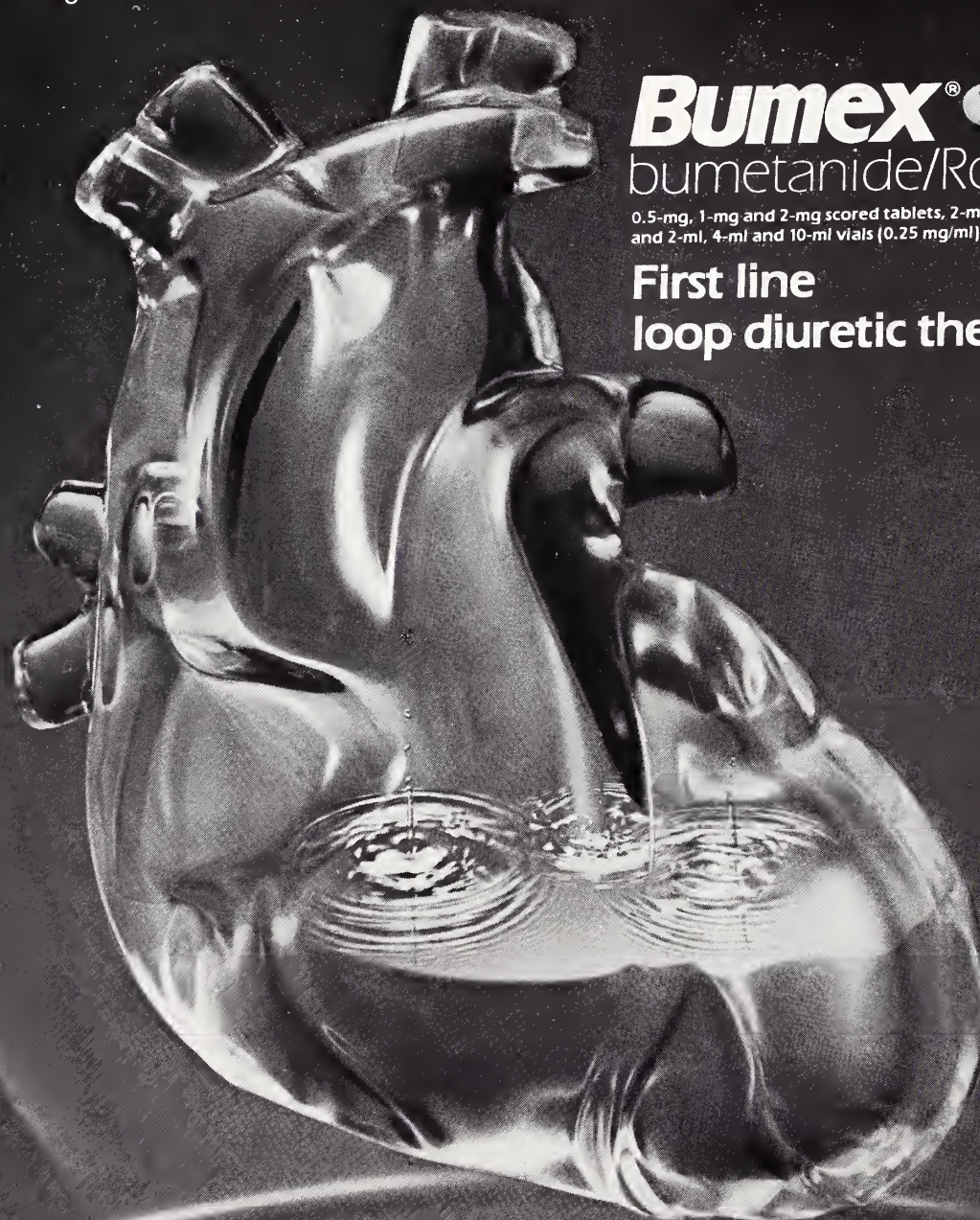
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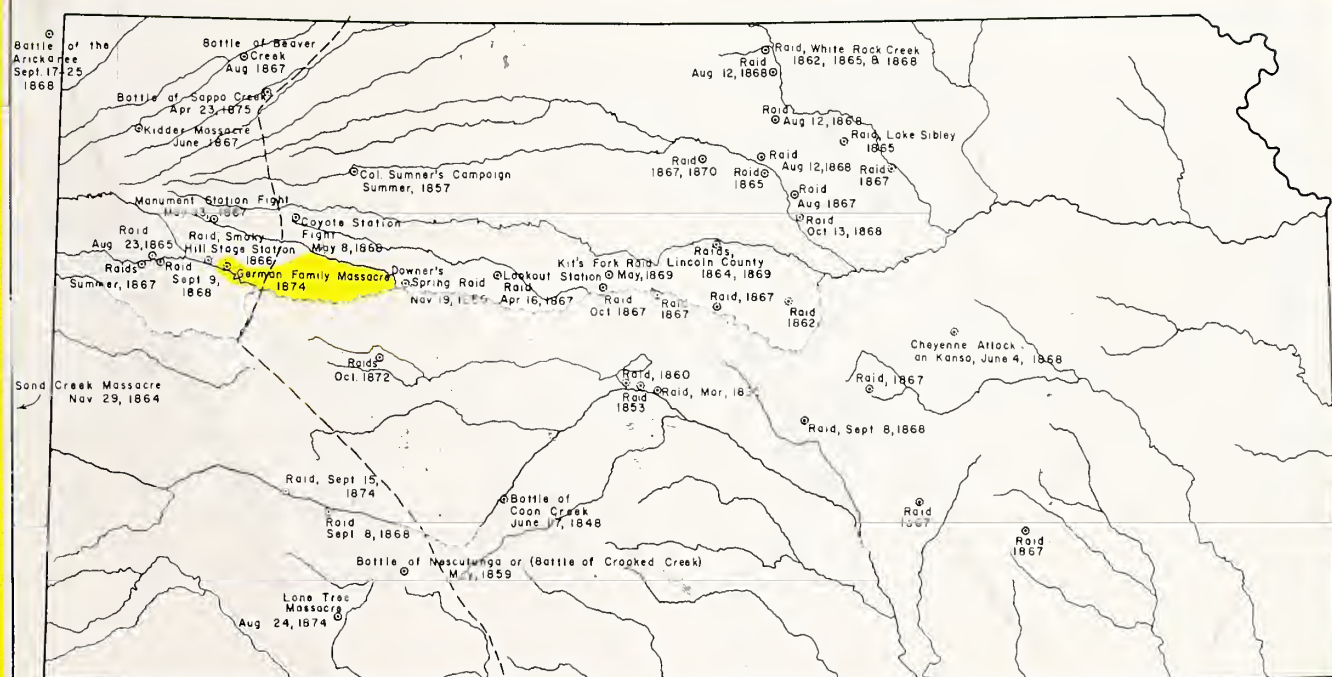
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Cover story — page 36

Asthma	46
Implications of Malpractice Litigation	50
KMS Newsletter	48a
Ribavirin	43
Unification Revisited	33

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Contents

Scientific Articles

- Ribavirin: Case Reports & Discussion — John M. Ziegler, M.D., Wichita
Ribavirin, recently released by the FDA, may provide effective treatment for RSV infections in children 43
- Asthma Complicated by Sinusitis — Kirit S. Patel, M.D. and James B. Neiburger, M.D., Kansas City, Kansas
Control of the asthmatic child requires careful assessment and long-term monitoring to assure the establishment of an effective individualized regimen 46

Miscellaneous

- A Personal View: *Unification Revisited: Taxation Without Representation* — David M. Leitch, M.D., Garnett . 33
- Alzheimer's and the Extended Patient 55
- Classified Advertisements 61
- Continuing Medical Education 58
- Cover Story 36
- Editorial Comment: *The Unrelenting Obligation* 49
- Impaired Physician Program Resource List 54
- Information for Authors 64
- KMS Newsletter 48a
- KMS Professional Liability Fund Contributors 63
- Medicina et Lex: Reflections Upon the Social Implications of Medical Malpractice Litigation* — Wayne T. Stratton, J.D., Topeka 50
- Physician Directory 60
- President's Message 48

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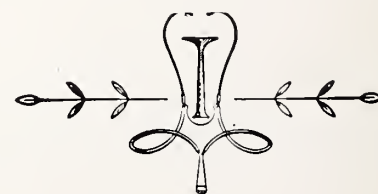
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A PERSONAL VIEW

Unification Revisited

Taxation Without Representation

DAVID A. LEITCH, M.D.,* *Garnett*

ON MARCH 29, 1985, the resolutions for the 1985 KMS Annual Meeting were sent from the KMS office to the presidents of component medical societies. Among them was #85-12, Subject "Unified Membership," submitted by Warren E. Meyer, M.D. (not otherwise identified, but who was at that time AMA alternate delegate according to KMS information). The date is important because the House of Delegates meeting was May 3-5, 1985, so component societies had only one meeting to read, understand, discuss, and instruct their delegates on this important issue. Coincidence?

This was the first meeting in the history of the Kansas Medical Society held outside the state boundaries, and many members had strong feelings either for or against this adventure. This "trip" also produced some interesting changes in the composition of the House of Delegates. A review of the official documents of the House shows that 31% of the delegates to the 1985 KMS meeting did not attend the 1984 annual meeting, nor did they attend the 1986 meeting either — at least in a voting position. A further review shows that 13% of the voting delegates in 1985 had attended the 1984 KMS meeting in an official capacity but did not attend the 1986 meeting. Is this because they didn't like unification? (Forty-two per cent of the voting delegates attended all three years reviewed — 1984, 1985 and 1986 — and of this 42%, two-thirds were officers, councilors, or past presidents.)

The meeting in Colorado Springs was enjoyed by many and there was no extensive discussion in the reference committee regarding 85-12. The discussion at the Second House of Delegates session was

sharp and democratic. All delegates who desired to speak on the resolution had that opportunity. However, few who were recognized voiced opposition, and the many who spoke in favor of 85-12 were convincing beyond even their expectations, as they later stated. Perhaps more importantly, some of these supporters spoke to the delegation as individuals and were not identified to the assembled delegates (31% new) as being AMA delegates or alternate delegates, which might have been important. At least others who were not AMA representatives identified the context in which they were speaking. Coincidence?

This resolution had many WHEREASEs, but failed to inform the delegates of some further WHEREASEs, and the results of some not discussed have caused great concern to some former KMS members. For instance, members who belonged to the BC/BS group health insurance through KMS and chose not to join unification received a letter that stated in part: "We have been advised by Blue Cross and Blue Shield of Kansas that the coverage for your Group _____, which is currently sponsored through the Kansas Medical Society Plan, will be terminated unless you continue your membership in KMS."¹ What would be your response if a member of your staff couldn't be insured because you changed groups? Would this information have influenced your vote as a 1985 KMS delegate? Is this arm twisting or just life?

Following his visits to the various Council Districts, KMS President Franklin G. Bichlmeier, M.D., wrote a letter dated October 17 to me (and presumably the other Councilors as well). In it he stated "The purpose of this letter is to ask you as Councilor to make a sincere effort to talk with members in your Council District over the next 3-4 weeks about this issue. I would like you to get a true feeling of the grass roots members in your district, and then let me know prior to our next Council meeting (Jan-

* Councilor, District 18.

Editor's Note: The opinions expressed in "A Personal View" are that — personal views of individual KMS members. KANSAS MEDICINE welcomes such expressions of opinion and denies any legal responsibility for their content.

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uary 17, 1987). At that meeting, I would like to have on hand a truly representative survey, by Council Districts, on the issue of united membership." It should have become apparent by now, some 18 months later, that those members who felt strongly against unification have not paid the unification dues and therefore were probably not present at any joint KMS President-District meetings to which, as non-members, they wouldn't have been invited. (Thirty-seven per cent of District 18's 1984 members have quit KMS as of this writing.) According to the minutes of the KMS Council for September 20, 1986, "Unified membership was the next subject for discussion. The council reviewed statistical data concerning KMS membership. It revealed that 5% of the total membership (11% of active dues-paying members) have dropped membership in KMS due to unification. The loss represents \$58,000 in dues. Members were reminded that unification was the result of the House of Delegates Resolution 85-12. The House is, therefore, the appropriate body to review this matter."

In order for the House of Delegates to "review this matter," a resolution must *and will* be written

to be voted upon to wipe out this change in the by-laws. In addition, the various county societies and other specialty groups should consider their previous action in light of the happenings of the last 18 months and instruct their delegates how to vote on this new resolution to rescind unification. This article is to provide information abstracted from KANSAS MEDICINE, correspondence written by KMS officers and staff, and personal observations, recollections, and secondhand comments made by others.

At this time — some 18 months after 85-12 — reevaluation of the previous decision is somewhat difficult. Eleven per cent of the former members are now gone from county societies and thus have no input into a "review" process. Do we make a sincere effort to include them in this reevaluation process? How do we go about doing this? It is obvious from the above that the third WHEREAS of 85-12 — "There is a proven need for broader representation. . ." — has in fact *not* been accomplished; rather, the opposite has been forced.

The fourth WHEREAS is also not turning out as stated. True, "there will be additional delegate

strength for the Kansas Medical Society," but this increase is more illusory than real as other states are blindly following the same sheep, so that by percentage, Kansas votes remain at about 1%. The last part of that WHEREAS — "and financial savings to our members through AMA unified state membership" — is most difficult to evaluate. I am forced to increase my current overhead by \$297.00 which is certainly not a savings (even though I get a "rebate" of 10%), and because of the 11% loss in dues paying members, there is already talk of raising KMS dues to those of us left. I leave it to each of you to decide what the AMA has done in the past 18 months *for you* in a positive, course altering action to influence your frozen fees, restraint of trade regulations through reimbursement by DRGs, and the proposed unified reimbursement of hospitals for all health care so you can grovel up to hospital administrators to get paid for your liability in practicing your chosen profession. What has the AMA done for your income, your taxes, and your blood pressure? Have you gotten your money's worth?

To further muddy the water about this organization we are currently forced to support, let's review a couple of current examples of the AMA in action. At a Council meeting, the assembled officers of your KMS organization were told by the AMA representative, Mr. Bud Wright, that present non-members would not be required to pay the full year's dues and could join for \$165.00. Even the KMS president (1985) Clair C. Conard, M.D. believed this as he stated in a letter to all KMS members who were not members of the AMA: "AMA dues for the remainder of 1985 are \$165.00."² (\$165.00 less 10% "rebate" = \$148.50.) However, when I proceeded in accordance with this advice I received a letter from KMS staff as follows: "We received your check in the amount of \$148.50 for AMA dues on July 10th leaving a balance due of \$148.50. We are scheduled to print our membership roster on Monday, July 21. In order for us to include you as a member in the roster, it will be necessary for you to forward the balance due prior to that date. We value your continued membership and involvement in the Kansas Medical Society, and appreciate your willingness to forward a portion of the AMA dues. Payment of the balance due will fulfill your financial obligations for membership."³ The letter was written in Topeka dated July 16. There was no way that letter could get to Garnett and return with the requested taxation by the stated deadline. Do you

(Continued on page 37)

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Cover Story

(This month's cover map was prepared by Homer E. Socolofsky and Huber Self for their Historical Atlas of Kansas, University of Oklahoma Press, 1972, and is used with permission.)

Slavery and the Civil War gave the state its sobriquet, "bleeding Kansas," but from the 1850s through the 1870s, more than 40 battles, massacres, and raids unrelated to them supported the reputation. At a time when danger was standard, no event exceeded the massacre of the German family for drama and pathos.

In 1870, John German, his wife, son, and six daughters left their native Georgia for life in the West. The morning of September 1, 1874, found them in the Solomon valley breaking camp and heading toward Fort Wallace. Attacked by a party of Cheyennes, the father, mother, son and two daughters were killed. The older girls — Catherine, 17 and Sophia, 12 — were taken captive for their usefulness. The two younger girls — Julia, 7 and Nancy, 5 — were spared only because a squaw intervened on their behalf. The party then turned south toward the home camp in Sand Point, Indian Territory.

A trader, coming on the site soon after, carried the news to Fort Wallace. Soldiers who investigated the area found the only surviving household item, the family Bible, from which they learned there were four girls not present among the dead and scalped bodies, and started in pursuit.

Meanwhile, the Cheyennes divided into two groups, the older girls going with one, the younger with the other. The little girls, after some days, wore out their welcome and were abandoned on the prairie. Wandering aimlessly, they chanced upon a wagon trail and, following it, came upon an abandoned campsite. With scraps of food and edible plants in the area, they managed to survive until found by yet another band of Cheyennes. This group, however, encountered a military search party which attacked the Indians and recovered the girls on November 7, 1874.

Catherine and Sophia had been separated but indeed put to work. The search continued for several months until this and other problems led to the surrender of 1600 Cheyennes at Cheyenne Agency, I.T., on February 26, 1875. Catherine, weighing 80 pounds, and Sophia, at 60, were released. The girls were transported to various army camps for recuperation (as the little girls had been) and all were reunited at Fort Leavenworth that summer.

Government funds were supplied for their support and they were placed with a foster family near Wetmore where they grew up and were educated. All were married and apparently continued farm life, which must have been restorative and healthy. Catherine died at 76 (ironically the original intent of the last trek toward Colorado was because of her precarious health!), Sophia at 85, and Julia at 92. Nancy's age at death is not recorded, but it is worth noting that she had 11 children. — D.E.G.



Before prescribing, see complete prescribing information in SK&F CO. literature or PDR. The following is a brief summary.

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Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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(Conjugated Estrogens Tablets)

Now the evidence looks better than ever

Significantly reduced risk of endometrial hyperplasia

Endometrial hyperplasia was significantly reduced when progestin was added to PREMARIN therapy for more than ten days a month.¹⁻⁴ The risk of endometrial hyperplasia may also be reduced through cyclic administration of unopposed, low-dose PREMARIN.

Effect on lipids—an important feature

PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.⁵

Low-dose control of menopausal symptoms*

PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

The most widely used, most extensively studied estrogen worldwide.

PREMARIN®
(Conjugated Estrogens Tablets)

Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe
vasomotor symptoms

PREMARIN® (Conjugated Estrogens Tablets)



0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

The appearance of these tablets is a trademark of Ayerst Laboratories.

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)

PREMARIN® Brand of conjugated estrogens tablets, USP

PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA.

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17 α -dihydroequilin, together with smaller amounts of 17 α -estradiol, equilin, and 17 α -dihydroequilin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe vasomotor symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass):** Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with

For atrophic vaginitis

PREMARIN® (Conjugated Estrogens)

Vaginal
Cream

0.625mg/g



caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

- Increased sulfobromophthalein retention.
- Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased nor-epinephrine-induced platelet aggregability.
- Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.
- Impaired glucose tolerance.
- Decreased pregnanediol excretion.
- Reduced response to metyrapone test.
- Reduced serum folate concentration.
- Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate to severe vasomotor symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically:* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

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- Barnes RB, Roy S, Lobo RA: Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985;66:216-219.

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Unification Revisited

(Continued from page 35)

remember the other play on dates? But more importantly, when I requested information as to the change in stated policy, I learned that *the information provided by our AMA representative was incorrect and a full year's dues was necessary.*

The second example is from a letter to Joseph F. Boyle, M.D., Chairman, HPA Steering Committee, AMA, from Jerry Slaughter written July 2, 1986. "I am responding to your letter addressed to Steven Carter. For your records, I have been CEO of the Kansas Medical Society for over two years now." Are they out front leading us, or are they "over two years" behind?

There are many examples I could cite from correspondence written by your officers and KMS staff regarding a "sell" campaign for unification. ("We hope these letters will "sell" the concept to the membership"; "We are about to begin an intensive communication process . . ."; "The following represents suggested guidelines for a plan of action at the local level to promote unified membership.") Sell campaigns are akin to indoctrination, reedu-



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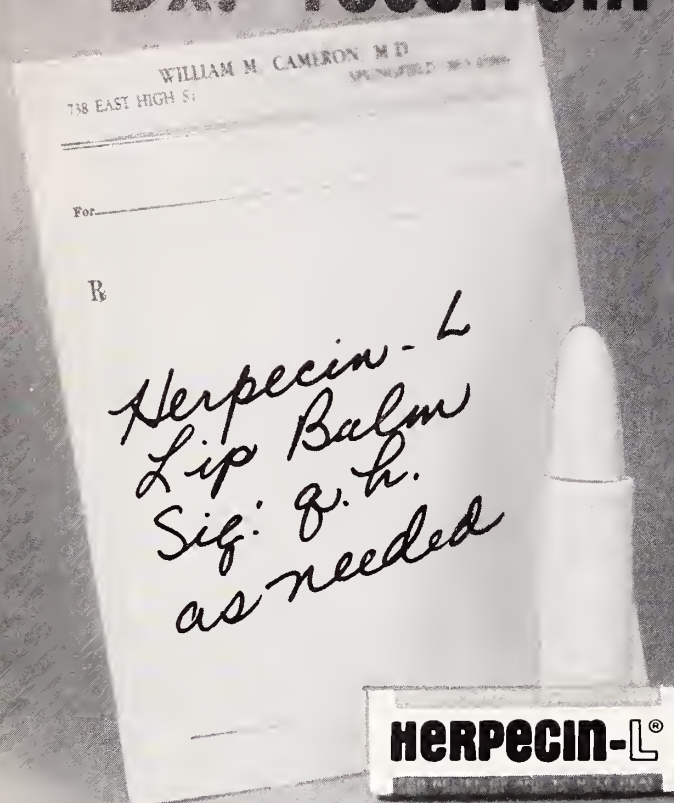
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cation, shove down your throat, or doublethink of 1984. Did you recognize any of this?

In KANSAS MEDICINE (July 1986), ten of 18 councilors voiced concern in their respective districts regarding unified membership. From all the scribbling (before reduced to type) I have presented for you to read and that has been reviewed by me, probably the most important words were written in the above issue by Carl Ambler, M.D., Councilor of the 12th District: "Many of our members — perhaps the majority — were somewhat disturbed by the passage of the Unified Membership Resolution at the 1985 House of Delegates meeting. Many of us felt that we were not adequately forewarned that such a decision was going to be made and that we had no opportunity to instruct our delegates. Many members feel that the grass roots membership should have had the opportunity to vote on this issue — perhaps in the form of a plebiscite."⁷

As our current KMS president has stated, "What we need is your input" so we can "move in the appropriate direction."⁸ This request was made to

the councilors October 17, 1986, as an informal survey. If this doesn't result in a vote of *ALL* members, current *AND* former, then you need to discuss 85-12 (Unified Membership) at your meetings and instruct your delegates how to vote on the soon-to-be-introduced resolution to repeal Unification (Tea tax?).

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3. Slaughter J: Personal communication. July 16, 1986.
4. Slaughter J: Personal communication to AMA Delegates and Alternates. May 9, 1985.
5. Conard CC: Personal letter as KMS President to all KMS members who were not AMA members. July 22, 1985.
6. Braun V: Personal letter as Assistant Director to Presidents and CEOs of local medical societies. November 6, 1985.
7. Ambler C: Council District Report, District 12. *Kansas Medicine* 87:7, 208, 1986.
8. Bichlmeier FG: Personal communication. October 17, 1986.



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Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks — month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

Generally well tolerated

Daily therapy with ZOVIRAX CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/vomiting, vertigo, and arthralgia.

The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

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Brief Summary

INDICATIONS AND USAGE: Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psychosocial difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

First Episodes (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

Recurrent Episodes:

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This

approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

CONTRAINDICATIONS: Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

WARNINGS: Zovirax Capsules are intended for oral ingestion only.

PRECAUTIONS: General: Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

Drug Interactions: Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parental doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F₁ generation. Although not statistically signifi-

cant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week post-dose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS — Short-Term Administration: The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

Long-Term Administration: The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

Chronic suppressive therapy for recurrent disease: One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

Intermittent Therapy: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

Patients With Acute or Chronic Renal Impairment: One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance ≤ 10 ml/min/1.73 m².

HOW SUPPLIED: Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200". Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.



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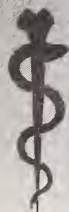
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SCIENTIFIC ARTICLES

Ribavirin: Case Reports & Discussion

JOHN M. ZIEGLER, M.D.,* *Wichita*

"It's JUST a virus, and we can't do anything to make it go away." That phrase used to be part of the catechism of pediatric training, but may no longer be appropriate. Advances in antiviral therapy are bringing many changes to pediatric therapeutics. R. Gordon Douglas, of the Cornell University Medical College, has noted that "all physicians should become familiar with [antiviral drugs] and with the concept that a number of significant viral illnesses may now be prevented or treated with specific chemotherapeutic agents."¹ Ribavirin is an antiviral agent recently released by the FDA for use in children with severe respiratory infections caused by respiratory syncytial virus (RSV). It was used to treat three patients at Wesley Medical Center during January 1986. Two case reports and a brief discussion of ribavirin are presented here.

Case One

A 10-week-old female was admitted to Wesley Medical Center because of a series of apneic spells associated with cyanosis. There was a one-week history of upper respiratory tract symptoms; a non-productive cough and wheezing developed three days prior to admission. There was no history of fever.

She was born at 36 weeks' gestational age and had no respiratory problems in the nursery. An "apnea workup" at the age of one month disclosed gastroesophageal reflux. The family history was positive for asthma and multiple environmental allergies.

The patient's temperature was 37.2C, pulse 168, respirations 48/min, and blood pressure 72/52 mm Hg. The weight was 4.84 kg. She was in moderate respiratory distress, with intercostal and supraclavicular retractions. Medium wet inspiratory rales were present bilaterally. Results of the remainder of the examination were normal.

Hematocrit was 31% and white blood count 17,800 cells/cu mm, with 31% neutrophils, 10% bands, 48% lymphocytes, and 11% monocytes. Capillary blood gas, obtained while the infant was breathing 40% oxygen, showed pH 7.37, PaCO₂ 44 mmHg, and PaO₂ 71 mmHg. Chest x-ray revealed bilateral hyperexpansion and infiltrates of the right middle and right lower lobes.

Early in the morning of the second hospital day she developed increasing respiratory distress. Arterial blood gas revealed pH 7.18, PaCO₂ 83 mmHg, and PaO₂ 30 mmHg. She was intubated and mechanically ventilated. Chest x-ray again demonstrated increased aeration, as well as patchy infiltrates bilaterally (*Figure 1*). A fluorescent antibody test on a nasopharyngeal aspirate was positive for RSV.



Figure 1. Portable AP chest x-ray demonstrates increased aeration, patchy right lower lobe infiltrates, and mild infiltrates on the left. The tip of the endotracheal tube is in good position in the mid-trachea.

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Because of her clinical deterioration she was deemed a candidate for ribavirin. The FDA has not approved the use of ribavirin in patients who are on ventilators (see below). Therefore, written informed consent was obtained from the parents for use of the drug in an unapproved manner. The drug was administered during periods of approximately 16 hours on each of the first two days of therapy, with the small particle aerosol generator (see below) connected to the ventilator tubing. She improved dramatically, was weaned to an oxygen hood on the fourth hospital day, and was treated with ribavirin on that day as well. The remainder of her hospital course was uneventful, and she was discharged in good condition.

Case Two

A 2-month-old white female with a clinical diagnosis of bronchiolitis was transferred to Wesley Medical Center because of respiratory distress. Born at term after an uncomplicated pregnancy, she was well until five days prior to admission when mild symptoms of an upper respiratory tract infection developed. Rhinorrhea and cough progressively worsened. On the day prior to admission, increasing respiratory distress developed and oral intake decreased. The next day she was taken to a local hospital and then referred to Wesley Medical Center. There was no history of fever, vomiting, or diarrhea.

The patient's temperature was 36.9C, pulse 155, and respirations 60/min. Blood pressures in the right and left arm and right and left leg were 85/50, 115/60, 90/65 and 110/85 mmHg respectively. She weighed 4.1 kg. Her respirations were labored, with intercostal and substernal retractions. Auscultation revealed mild inspiratory rales and moderate expiratory wheezes bilaterally, with good air exchange. The precordium was quiet, with no thrills, lifts, or heaves. An S₃ gallop rhythm was present. A grade III/VI plateau-shaped holosystolic murmur was heard along the left sternal border, with radiation across the precordium and to the back. Femoral pulses were ++ bilaterally. The abdomen was soft and protuberant; the liver edge was palpable 4 cm below the right subcostal margin. The spleen was not felt. Results of the remainder of the examination were normal.

Hematocrit was 31%, and white blood count 12,500 cells/cu mm, with 34% neutrophils and 64% lymphocytes. Serum electrolytes were normal. However, there was a reversal of the Na⁺/K⁺ ratio in the urine, with a sodium concentration of



Figure 2. Portable AP chest x-ray reveals increased aeration, infiltrates in the right upper and right middle lobes, cardiomegaly, and increased pulmonary vascularity.

15 mEq/l and a potassium concentration of 78 mEq/l. Arterial blood gas, drawn while the patient was receiving oxygen at 3 l/min via face mask, revealed pH 7.33, PaCO₂ 45 mmHg, and PaO₂ 121 mmHg. Chest x-ray revealed increased aeration of the lungs with infiltrates in the right upper and right middle lobes. In addition, cardiomegaly and increased pulmonary vascularity were noted (*Figure 2*). EKG revealed mild left atrial enlargement and combined ventricular hypertrophy. A fluorescent antibody test for RSV from a nasopharyngeal aspirate was positive.

Oxygen was continued. Administration of furosemide resulted in a brisk diuresis, and fluids were restricted to 60 cc/kg/day. Digoxin was begun parenterally. Because of the likelihood of congenital heart disease and the confirmation of RSV infection, specific antiviral therapy was begun. Ribavirin, delivered into an oxygen hood, was continued for three days; she was weaned to room air by the fifth hospital day. Congestive heart failure was controlled with digoxin and furosemide. The hospital course was complicated by severe hypertension, with blood pressures higher in the upper extremities. Cardiac catheterization later confirmed a coarctation of the aorta. The child was discharged on the tenth hospital day in stable condition. Discharge medications included digoxin and furosemide.

Historical Overview

Ribavirin is a nucleoside analog bearing the chemical name, 1 β -D-ribofuranosyl-1,2,4-triazole-3-carboxamide. It was first synthesized in 1970, as part of a controlled search for nucleoside analogs that would be useful clinically as antiviral agents. In vitro studies demonstrated that ribavirin has a very broad spectrum against both RNA and DNA viruses. There is evidence that the drug is capable of more than one type of antiviral effect, although there is uncertainty about the specific mechanism(s) of action.²

In vivo animal studies began in the early 1970s. It was found that "the efficacy of the compound is quite dependent on the site of the infection, the manner of treatment, the age of the animal, and the virus dosage utilized. Infection sites most sensitive to ribavirin include the lower respiratory tract, liver and cutaneous surfaces."²

Volunteer trials in humans began in the mid-1970s, and initially examined the effect of ribavirin on experimentally induced and naturally acquired influenza infections. Early studies, using oral administration, "yielded mixed results . . . depending on the virus and the treatment regimen."² In 1981, Knight *et al* published their results of treatment of influenza in humans using small particle aerosol as the mode of administration.³ Aerosol administration allows delivery of the drug directly to the site of infection. An obvious advantage is that the minimum effective dose may be much lower than when the drug is administered orally or intravenously. These results were very encouraging, and soon thereafter ribavirin was used successfully in treatment of experimentally acquired RSV infection in adults.⁴

Studies of ribavirin use in children with RSV first appeared in 1983. In one prospective, randomized, double-blind study of 26 children with RSV bronchiolitis, ribavirin therapy was found to improve the course of the illness by day three of therapy.⁵ In another prospective, double-blind study of 33 infants, those who received ribavirin were significantly improved clinically after four days of therapy, and infants treated with ribavirin had higher arterial oxygen saturation levels in room air by the end of the treatment course. In addition, viral shedding was significantly decreased by the end of therapy in infants who received ribavirin.⁶

More recently, 26 children with lower respiratory tract disease and documented RSV infection were followed in a prospective, randomized, double-blind fashion. Infants who received ribavirin demon-

strated clinical improvement as early as 24 hours into therapy. Arterial oxygen saturation in room air improved during the course of therapy in infants treated with ribavirin, but not in those patients who received placebo. Viral shedding was significantly decreased by the fifth day of therapy.⁷

Toxicity of the drug is minimal. When delivered as a continuous aerosol, no adverse effects have been noted. Human volunteers who received high oral doses have developed anemia and increases in serum aspartate aminotransferase (SGOT) and bilirubin, all of which were reversible on termination of therapy. Teratogenicity has been demonstrated in rats.²

Administration

Ribavirin is administered as an aerosol, using a small particle aerosol generator supplied with the drug. The 6-gm vial is dissolved in 300 ml of sterile water, yielding a final concentration of 20 μ g/ml. Delivery of the drug is usually accomplished through a face mask or oxygen hood. It is possible to use the drug on patients who are intubated and ventilated; however, there are certain risks involved with this method, and the FDA has not yet approved the use of ribavirin in this manner. The risks generally involve mechanical malfunction of the ventilator resulting from precipitation of the drug onto the equipment. Regardless of the specific manner of administration, the aerosol is delivered continuously for 12-18 hours a day, and repeated daily for three to seven days or until there is significant clinical improvement.

Specific Viral Diagnosis

Essential for the judicious use of ribavirin is the ability promptly to confirm RSV infection of respiratory tract epithelial cells. The following method is used at Wesley Medical Center:

Specimens for direct antigen tests and cultures are collected by aspirating nasopharyngeal secretions with a 16-gauge cutdown catheter attached to a 3-ml syringe. Alternatively, the tubing from a 19-gauge infusion set can be used. Instillation of 2-3 ml of normal saline may be used to help loosen the secretions, if desired. The aspirated material is transferred into 2 ml of virus transport medium and centrifuged at 1000 rpm for ten minutes. The supernatant is removed, and the cell pellet is resuspended in 5-10 ml of phosphate-buffered saline and centrifuged again. The washed pellet is resuspended in 20-100 μ l of phosphate-buffered saline contain-

(Continued on page 52)

Asthma Complicated by Sinusitis

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REACTIVE AIRWAY disease (asthma) frequently causes considerable morbidity in the pediatric population. Three to five per cent of children are affected, and it is a common cause for emergency room visits and hospital admissions.¹

The long term management of an asthmatic child is a challenge for the physician and, although exacerbations of asthma occur, the causes of the exacerbation are often subrogated in favor of acute management. Causes known to precipitate asthma attacks include allergen overload, viral and bacterial infections, febrile illnesses, changes in temperature, humidity and wind, exposure to non-specific irritants (smoke, fumes, etc.), inadequate treatment, and non-compliance.

Some patients who experience difficulty in controlling asthma symptoms may also have symptoms of chronic purulent rhinorrhea, post-nasal drip, nocturnal and postural (especially supine) cough, despite multiple oral and inhaled medications. At times, acute or chronic paranasal sinusitis is the suspected explanation for the downhill course. When those patients are treated with appropriate antibiotics for a reasonable length of time, rapid return to control has been observed. Presented here is a case that illustrates this type of clinical picture.

Case Report

A 10-year-old black male was followed in the Pediatric Allergy Clinic at the University of Kansas Medical Center for five years. Initial diagnoses were seasonal and perennial allergic rhinitis and perennial reactive airway disease (asthma) with seasonal exacerbations. Symptoms included sneezing, itching eyes, cough and intermittent episodes of wheezing, especially in spring and fall. The patient's 3-year-old sister also has asthma. The patient has frequent contact with dust, molds, and a newly acquired cat.

The diagnoses were confirmed by skin tests which

demonstrated significant reactions to various molds, spores, ragweed and tree pollens, housedust, and cats. Avoidance was advised for the cat, housedust, and mold allergens. Pharmacologic management included Slo-Bid (theophylline) 200 mg/8 hrs po, Intal (cromolyn sodium) by spinhaler 20 mg tid, Alupent (metaproterenol) 10 mg orally tid as needed for wheezing. Allergen immunotherapy was initiated for housedust, mold, ragweed, and tree allergens but was discontinued after three months due to poor compliance.

In September 1985, the patient presented at the Allergy Clinic with a history of daily episodes of wheezing and dyspnea, nasal obstruction, sneezing, and watery nasal discharge for three to four days. There was no fever. Physical examination revealed "allergic shiners," Dennie-Morgan lines, and a serous nasal discharge with swollen inferior and middle nasal turbinates. Auscultation of his chest revealed scattered rhonchi in both lung fields and, on forced expiration, a productive type cough. Computerized spirometry before and after inhalation treatment with Alupent (metaproterenol) 5% solution 0.3 cc in 3 cc normal saline showed a significant improvement following treatment (*Table I*). He was released with Predisone 20 mg orally for two days, then tapered over a period of four days, while usual medications were continued.

Two weeks later, he presented at the Medical Center emergency room in acute respiratory distress. He had experienced wheezing and coughing episodes for one week. He was given epinephrine (1:1000) 0.3 cc subcutaneously twice and a nebulization treatment with Alupent (metaproterenol 5% solution) 0.3 cc in 3 cc saline. Physical examination revealed that he had muco-purulent nasal discharge, audible wheezing, productive cough, intercostal retractions, dyspnea, and tachypnea. He was afebrile. He was admitted to the hospital and started on intravenous Aminophylline 1 mg/kg/hr, Solu-Medrol (methylprednisolone) 2 mg/kg as a loading dose and in divided doses every six hours; inhalation treatments with Alupent (metaproterenol 5% solution) 0.3 cc in 3 cc saline were given every three to four hours. On this regimen, he showed minimal improvement for two days.

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TABLE I
RESULTS OF COMPUTERIZED SPIROMETRY

	FVC		FEV1		PEFR		MMEFR	
	L/Sec	%	L/Sec	%	L/Sec	%	L/Sec	%
Pre-inhalation	2.08	86	1.80	86	3.57	106	0.99	34
Post-inhalation	2.24	93	1.84	89	3.67	108	1.90	67
Post-hospital treatment	2.59	107	2.24	108	4.58	132	2.85	100

During this time his serum theophylline level was 16.1 mg/dl. Total WBC was 23.7 with 73 polymorphonuclear cells, 20 bands, 5 lymphocytes, and 2 monocytes. The erythrocyte sedimentation rate was 35 mm/hr and an initial arterial blood gas study on room air revealed a pH 7.43, pCO₂ 31 torr, and pO₂ 69 torr. Sputum and throat cultures revealed normal flora; two blood cultures were negative. Urinalysis and serum electrolytes were normal.

Chest x-ray revealed a left lower lobe infiltrate initially, but this had cleared three days later, strongly suggesting stalactasis.

The patient's poor response to treatment prompted a consultation with the Division of Allergy. On examination, the patient was found to have bilateral tenderness over the maxillary bones and scattered rhonchi over both lung fields on auscultation. Paranasal sinus x-rays were advised and demonstrated opacification of both maxillary and the left ethmoid and sphenoid sinuses. Antibiotic therapy with ampicillin 1 gm intravenously/6 hrs was initiated, and the patient recovered rapidly with clearing of respiratory symptoms. He was released two days later to continue Slo-Bid 200 mg/8 hrs, Intal (cromolyn sodium 20 mg) capsules by spinhaler tid, Prednisone tablets 30 mg/day to be tapered over six days, and ampicillin capsules 1 gm/6 hrs orally for 15 days.

He was asymptomatic at the time of a followup visit to the Allergy Clinic five days later. Physical examination showed patent nasal airways and absence of nasal discharge. His lungs were clear on auscultation. Spirometric examination (*Table I*) showed marked improvement from previous measurements, and results were within normal limits.

Discussion

This case serves as an example of sinusitis that complicated the management of asthma and precipitated hospitalization. The patient responded dramatically to antibiotic treatment.

Abnormal sinus x-rays have been observed in 53% of pediatric patients with respiratory allergy.²

This has led to increased frequency of exacerbation and poor control of asthma despite regular use of medications and addition of supplemental medications, particularly corticosteroids.³ This clinical association of asthma and sinusitis was first observed by Gottlieb in 1925⁴ and Bullen in 1932,⁵ then seemed to be lost in the medical literature for a good half-century. Recently, interest in this clinical association has been rekindled with reports by Rachflesky *et al* in 1978.² In subsequent years, a number of substantiating reports were published in the pediatric and allergy literature.

The microbiology of sinusitis has been described in detail in the pediatric, infectious disease, and otolaryngologic literature. Most studies agree that *Hemophilus influenzae*, *Streptococcus pneumoniae*, and *Branhamella catarrhalis* account for 65% of positive bacterial cultures in acute cases. *Streptococcus viridans*, *Hemophilus influenzae*, *Staphylococcus aureus*, and a number of anaerobes (*Pseudomonas*, *Klebsiella*) are predominant in chronic cases.³

The mechanisms by which paranasal sinus disease complicate asthma remain unknown, but several hypotheses have been proposed:

1. Bacterial seeding of lungs and bronchii from sinuses by muco-purulent material leading to inflammation of the bronchial and tracheal mucosae;
2. Enhancement of pre-existing beta-adrenergic blockade by the infectious process in the bronchii and trachea; and
3. Reflex bronchospasm mediated through the vagal parasympathetic nervous system, especially the receptors in the nose and sinuses via trigeminal (afferent fibers) and vagus nerves.⁶

Sinusitis is diagnosed primarily by clinical observation. Children may not present with the classical symptoms of facial pain, headache, post-nasal drip, or fullness in the paranasal area and maxillary tenderness on percussion. Symptoms of purulent rhinorrhea, nocturnal and positional cough, and

(Continued on page 60)

PRESIDENT'S MESSAGE

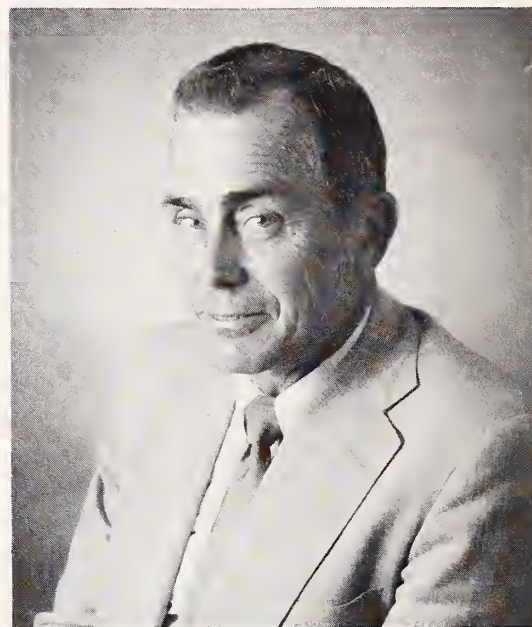
TODAY, in spite of all efforts, the cost of practicing medicine continues to rise. Malpractice insurance premiums are a large part of this escalating cost.

During the past two years, Kansas physicians with the KMS staff were successful in securing tort reform legislation — especially HB 2661 with which we're all familiar. We all recognized at the time that it would be at least two to three years before this legislation would have any significant effect on the current high costs of malpractice insurance; what we didn't anticipate was the magnitude of the ongoing cost increases by the insurance companies writing this insurance for Kansas physicians.

Pennsylvania Casualty (PHICO) announced recently that they were restricting their underwriting in Kansas. Medical Protective received an increase of approximately 45% in 1985 and did not increase recently. However, Medical Defense Insurance Company received a 60% increase, and in late summer St. Paul Insurance Company asked for a 20-30% increase in premiums, which was denied, only to have them return in January with a request for a 65% increase.

These data indicate that insurance costs relative to malpractice premiums in Kansas will not go down and may continue to rise during the next one to three years.

I think we as physicians need to consider two possible actions. The first is to place all physicians under the joint underwriting association (the state-run insurance company); the second is to sponsor



legislation that would totally eliminate the Health Care Stabilization Fund in a phased-out manner, thus returning us to the conventional marketplace.

These are only a couple of options, and both are significant changes in policy with many ramifications. However, we must evaluate all available long-term strategies in the search for a stable malpractice environment. We will continue to monitor the situation and act upon this persistent and insidious problem as appropriate.

A. D. Bickelmeier MD

President





KANSAS MEDICAL SOCIETY

Newsletter

1300 Topeka Ave. • Topeka, Kansas 66612 • (913) 235-2383

FEBRUARY 1987

LEGISLATIVE UPDATE

After about one month's work, the legislature is finally building up a full head of steam, and several important issues are beginning to work through the process. After the initial flurry of activity on lottery, parimutual racing and liquor by the drink legislation, the legislature has settled into its annual routine of considering the mass of new legislation introduced each year.

Several issues of interest to medicine have surfaced--some expected, others not. A brief run down on the issues follows:

Optometric Scope of Practice. S.B. 113 has been introduced by the state's approximately 300 optometrists, and it would authorize the use of therapeutic drugs, authorize removal of foreign bodies, and allow the treatment of glaucoma by optometrists. The bill is similar to legislation introduced last year, and it's part of a nationwide effort among optometrists to push for expanded practice privileges. Optometrists claim they are as well trained as family physicians and others to be the primary point of eye care for the citizens of Kansas. KMS is strongly opposed to this legislation, and encourages physicians to contact their legislators and express opposition to the bill.

Healing Arts Board Amendments. Three pieces of legislation--Senate Bills 33, 34 and 35--all make extensive amendments to the Healing Arts Act, the law which governs the conduct and regulation of physicians, chiropractors, and others. S.B. 33 changes the composition of the Board by adding two members of the public (for a total of 3) and deleting one M.D., one osteopath, and one chiropractor. (KMS opposes this bill.) S.B. 34 establishes a full-time executive director for the Board, in an attempt to consolidate the administrative responsibilities of the various staff people into one position. The executive director would be employed by the Board, subject to the approval of the State Senate, and may be a licensed physician, but not necessarily so. (KMS supports S.B. 34). S.B. 35 principally makes technical amendments to the law, although it would establish biennial licensure for all licensees of the Board. (KMS opposes this provision because it creates administrative problems with CME requirements and annual malpractice insurance renewals.) The bill also makes several technical amendments relating to the registration of physician assistants, an issue that became more controversial recently when the Attorney General ruled that PAs may prescribe drugs. (KMS opposes independent prescribing authority for PAs, and will be offering amendments to put such a prohibition in the law).

In This Issue...

- Legislative update
- KMS resolutions
- Medicare
 - Laboratory services
 - Bad debt payments
- AIDS: AMA report
- Insurance processing/coding seminar
- Communicable diseases reporting
- Congressional address changes
- Medical office management seminar
- CPT 1987 edition
- Dementia diagnosis
- Dr. Collins named director
- Safety belt use
- Tax strategies seminar

Retired Physician Malpractice Exemption. S.B. 36 is the result of a request KMS made last summer to an interim committee and would allow retired physicians to maintain a full, active license to practice medicine, but be exempted from the mandatory malpractice insurance requirement. KMS strongly supports the measure because it will make it possible for retired physicians to do certain kinds of volunteer work, etc. that require an active license to practice, but will relieve the physician of the mandatory insurance burden.

There are many more health-related bills which have been introduced, and a full summary of pending legislation is contained in the Legislative Bulletin sent to all members in a separate mailing. If you have any questions about the above legislation or any other bills, please contact the KMS office.

KMS RESOLUTIONS

The KMS Annual Meeting will be April 30-May 3 at the Holiday Inn Holidome, Manhattan. If you wish to submit resolutions for consideration by the House of Delegates, please send them to the KMS office without delay.

PHYSICIAN LAB SERVICES MEDICARE CHANGE

Under the new COBRA regulations, physicians who furnish clinical diagnostic laboratory services in their offices must accept the Medicare assigned fee as full payment for these services; beneficiaries deductible and co-insurance are waived. If a non-participating physician who doesn't accept assignment bills the beneficiary for these services, the tests will be considered not to be covered and no reimbursement will be made. Allowances are limited to 115% of the national median laboratory fee schedule.

AIDS STATUS REPORT

The AMA report of the Board of Trustees (Report L) is available on request from the KMS office, 1-800-332-0156.

*
* INSURANCE PROCESSING The Kansas Medical Assistants Society will sponsor an all-
* AND CODING day seminar on "Insurance Processing and Coding for the
* Medical Office on Sat., March 28, 8:30 a.m. to 4:00 p.m. at
* the Ottawa University Student Union. (Not designed for anes-
* thesiology, radiology, pathology, or psychiatry because of
* unique coding problems in those fields.)
*
* Approved for .6 CEUs. Fee includes the 1987 CPT & Workbook.
* AAMA members \$75; nonmembers, \$100. Non-members who join at
* the time of the seminar may apply \$25 of the registration
* to 1987 dues (\$70).
*
*
*

REGISTRATION FORM

* Name _____ Employer _____
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* City _____ State _____ ZIP _____
*
* Amount enclosed _____ Please make check payable to the KMAS Education Seminar.*
*
* Registration deadline March 7, 1987; no refunds after that date.
* Send to: Cora Kunard, CMA, 1320 Ash, Ottawa KS 66067.
*

IMPORTANT REMINDER:
REPORTING COMMUNICABLE
DISEASES

All physicians are required by law to report deaths of persons who have, or are suspected to have, communicable diseases. This is true whether the patient recovers or dies and--in the latter case--whether the disease in question was or was not the immediate cause of death. If you have the required forms, you may make such reports directly to the Kansas Department of Health and Environment; otherwise, such diseases may be reported through your county health department.

In addition, it is incumbent upon the physician to notify the mortician when a patient has died of a communicable disease so that appropriate precautions can be taken in preparation of the body for burial. Failure to comply with this regulation can be the basis for recovery in a civil action and is also grounds for disciplinary action under regulations of the Kansas State Board of Healing Arts and the Kansas Department of Health and Environment. These laws and regulations are of special significance in the present atmosphere of the AIDS threat.

CONGRESSIONAL
ADDRESS UPDATE

Four of the five Kansas Representatives in Congress have moved to different offices. Here are the addresses where you can write to them in Washington DC 10515 (* denotes new address):

Pat Roberts, 1314 Longworth House Office Building
*Jim Slattery, 1440 Longworth House Office Building
*Jan Meyers, 315 Cannon House Office Building
*Dan Glickman, 1212 Longworth House Office Building
*Robert Whittaker, 2436 Rayburn House Office Building

The addresses for Senators Dole and Kassebaum and the phone numbers for the senators and all representatives are correct as published on page 16 of the annual directory, the August issue of KANSAS MEDICINE.

MEDICAL OFFICE
MANAGEMENT WORKSHOPS

The KMS is again sponsoring a set of five medical office management workshops. They will be conducted on March 18-19 at the Holiday Inn-Holidome in Salina, by Ed Kelsay, Attorney-at-Law. Fees for "Personnel Management," "Marketing," "Telephone Collecting," and "Computers" are \$50 each; for "Improving Patient Treatment Treatment," the fee is \$25. To register, send a check payable to KMS Services, with the completed registration form, to the Kansas Medical Society, 1300 Topeka Avenue, Topeka KS 66612.

Names:	Workshop # & Date	From the office of:
1. _____		Name _____
2. _____		Address _____
3. _____		City _____ State____ ZIP_____
4. _____		Phone _____ Specialty_____

NEW CPT AVAILABLE

The 1987 edition of the CPT code book is now available from the AMA. Cost is \$30; AMA members receive a 20% discount. Send order and payment to: Book & Pamphlet Fulfillment--OP-341/7, American Medical Association, P.O. Box 10841, Chicago IL 60610-0946; or you may charge it to VISA or MasterCard by calling, toll-free, 1-800-621-8335.

HHS "COLLECTION AGENCY"?

HHS is considering a plan to deduct unpaid Medicare hospital bills from Social Security checks. The Wall Street Journal reports that garnishing the checks would require Congressional action, but HHS officials believe that they could by regulation refuse to pay bad debts to hospitals. During a five-year period, the federal government pays \$1.2 billion in Medicare bad debts.

DIAGNOSIS OF DEMENTIA: NIH

The National Institutes of Health will conduct a conference on "The Differential Diagnosis of Dementing Diseases" on July 6-8 in Bethesda, Maryland. It will address issues of definition of dementing diseases and which can be arrested or reversed, evaluation of patients, diagnostic tests, and priorities for future research. For further information, contact Ms Marti Bernstein, Prospect Associates, Suite 500, 1801 Rockville Pike, Rockville MD 20852; 301-468-6555.

DEAN T. COLLINS, M.D.

Dean T. Collins, M.D., has been named director of psychiatry at The Menninger Foundation. In this position, he will represent the Foundation's 70 psychiatrists at the management level. Dr. Collins has been active in KMS activities and has served on a number of committees.

SLOW DOWN & BUCKLE UP!

The Kansas Department of Transportation has erected signs to remind motorists of the state's safety belt law. In a related matter, a new study by the department reveals that only about 40% of Kansas motorists comply with the 55 mph speed limit, and only about 20% comply on the most dangerous roadways.

TAX STRATEGIES AFTER TAX REFORM

A tax reduction workshop will be sponsored by the Kansas Medical Society on March 14, 1987, at the Wichita Hilton Inn East. Registraton fees include workbook, coffee breaks, and lunch. Send your registration and check payable to KMS Services, Inc., 1300 Topeka Avenue, Topeka KS 66612; or call 1-800-332-0156 or 913-235-2383. Take advantage of pre-registration rates!

Pre-registrations postmarked by March 3, 1987

KMS Member	\$125.00
KMS Member with Spouse or Office Assistant ..	\$200.00
Non-KMS Member	\$200.00
Non-KMS Member with Spouse or Office Assistant	\$275.00

Registration after March 3, 1987

KMS Member	\$150.00
KMS Member with Spouse of Office Assistant ..	\$225.00
Non-KMS Member	\$225.00
Non-KMS Member with Spouse or Office Assistant	\$300.00

Name _____	Spouse or office assistant _____
Address _____	_____
City _____ State _____ ZIP _____	Amount \$ _____

EDITORIAL COMMENT

IT IS A rare day when nothing is conveyed to the medical profession and the public regarding AIDS. A not surprising aspect of the matter has been voiced in a commentary in the *JAMA* by a medical student reflecting his observations of those charged with caring for its victims. He observes (not unsympathetically) that the distressing medical and social characteristics of the disease may produce, more than in many diseases, a blunting effect on the emotional support house staffs can call up when confronted daily with these frustrations.

The most publicized modes of transmission as recognized at the moment — homosexual behavior and unclean drug abuse equipment — do not always inspire the type of concern so necessary in dealing with those patients most likely to be suffering from AIDS. Those in teaching institutions are apt to be saturated with these and other distressing cases inviting an understandable but unfortunate emotional anesthesia. But the basic problem did not arrive with AIDS. From its beginning, the profession has been confronted with the stress of providing that type of support — may well have originated it because no one else (other than the mothers of the tribe) would do it. The easy problems are disposed of quickly. Those problems which, by their character, lack definitive and effective care have been the physician's greatest challenge intellectually and emotionally.

It is interesting, then, that the handling of such feelings has never entered the medical curriculum in a formal sense. Perhaps this is because there is no suitable way to translate this into terms of consistent meaning to the student-recipient or suitable manner of testing the student's ability and understanding in supplying this therapy as, for example, the signs and symptoms of a retroperitoneal lesion or the management of juvenile diabetes. It has been assumed that students would have a certain inherent capacity to meet these problems with the proper degree of sustained compassion or absorb it by some philosophical osmosis from their instructors.

The thought has been expressed that each physician-product personified a certain form of that phenomenon and, in the manner of water seeking its own level, would be drawn to those forms of practice (or its delivery) requiring available emotional durability — or attract those patients accord-

The Unrelenting Obligation

ing to their need for it. There have always been individual voices within the profession urging maximum attention to emotional support of patients, both to augment specific remedies and to provide a necessary form of assistance when they were lacking. (The third point of the oft-quoted triad, "to comfort always," is a case in point.) The implementation, however, has been entirely a matter of the individual's capacity — and the patient's interpretation.

It is often assumed that the so-called cognitive practice forms are more productive of those conditions calling for the compassionate attitude. Before the surgical specialties rise up in wrath, it should be pointed out that *every* branch of medical care is essentially cognitive. The specificity of a surgical procedure may be a significant punctuation in the patient's care, but the preparation for it and the aftercare are as demanding as any service. Recent years have seen an increasing involvement in patient contact of those groups traditionally more detached — the radiologists and pathologists, for example.

At the same time, there has been an increasing awareness of physician vulnerability as expressed by physician impairment and suicide. Once these were regarded as unfortunate but rare aberrations of the medical personality. The profession has come to realize increasingly that it has a responsibility to those physicians and the public to identify methods of detection and assistance that will serve those physicians, their patients and, by extension, the profession and the public.

The changing medical scene has led to calls for addition to the medical curriculum of some instruction in the economics of medical practice — personal and professional. Perhaps the introduction of a course in augmenting emotional support would be as desirable in its own way. At the moment, the form of such a course seems a little fuzzy, and we shall have to rely on the student's inherent ability to understand and implement this important element of practice. Or perhaps the two could be combined since the economics of the day seem to produce an increased demand for the latter. — D.E.G.



MEDICINA ET LEX

Reflections Upon the Social Implications of Medical Malpractice Litigation

WAYNE T. STRATTON, J.D.,* *Topeka*

MUCH HAS BEEN written about the fallout from the recent explosion in medical malpractice litigation. Attempts have been made to identify and price the costs of defensive medicine.

During the past two years, premiums have skyrocketed, with costly differentiation between classes of physicians covered by insurance. While it's impossible to quantify from present data, anecdotally it appears that this has caused the largest shift in the provision of health care since the disruption caused by World War II.

The general practitioner has been forced to reassess the economic benefit associated with each procedure and to decide whether it can be justified in today's climate.

Many physicians no longer deliver babies or have restricted their practice in some other fashion. Some have found employment with hospitals or other organizations willing to pay their insurance premiums (and also willing to assume some of the burden of record keeping and billing). Many physicians now retire earlier than previously because they find they are working harder for less compensation. Does society benefit from these changes?

If present trends continue, all babies born in Kansas will soon be delivered in 10 or 12 hospitals. The aged who require surgery or intensive medical care will soon spend their final hours miles away from home, family, and friends.

* KMS Legal Counsel

Editor's Note: This is the 16th in a series of regular columns concerning current subjects of legal interest to physicians. For the sake of brevity and clarity, citations and footnotes are omitted.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE or the Kansas Medical Society. For further information, contact Mr. Stratton, 215 E. 8th, Topeka, KS 66603; 1-800-332-0248.



If government decided, as a deliberate reflective act, to structure the health care system in such a manner, there would be cries of protest from the public. Kansas physicians and other health care providers have done much for the state by providing health care planning. The evolving situation, however, is occurring without planning by any party, much less health care providers or the state of Kansas. With few exceptions, the changes have gone unnoticed.

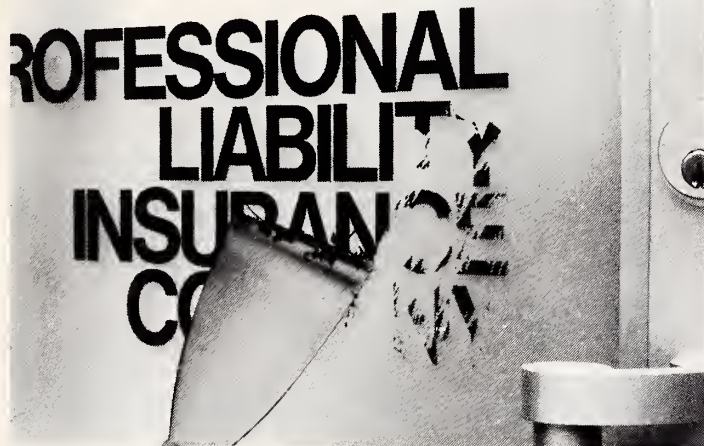
The ability of the tort system to effect social changes has been demonstrated on many occasions. Lawyers point with pride to instances in which industries have adopted safe practices as a result of litigation. Certainly there have been instances in the health care field in which the potential for injury has been emphasized by litigation.

The fallout from the present situation, however, presents more drastic changes. Who can assess the loss to society of the pool of physicians who no longer provide health care? What are all the tangible losses sustained by many rural Kansans as a result of the restructuring of the availability of health care?

Some of the changes may be directly identified. Would the economic health of the state be better if

(Continued on page 53)

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Ribavirin

(Continued from page 45)

ing 2% fetal bovine serum. A small drop of the resuspended material is placed on a slide to give a spot no larger than 1 cm in diameter. The slide is air dried and fixed in acetone at 4°C for ten minutes. It is then stained with fluorescein-conjugated monoclonal antibody to RSV (Ortho Diagnostics, Raritan, New Jersey) according to the manufacturer's directions, and examined with a Zeiss incident light fluorescent microscope for epithelial cells with characteristic fluorescence.

Indications for Use

FDA recommendations are that ribavirin be reserved for use in "infants and young children with severe lower respiratory tract infections due to respiratory syncytial virus" (product insert). Although RSV bronchiolitis is a common disease in infancy, most children have a mild course. Even for the minority who are hospitalized, most can be managed adequately with supplemental oxygen and parenteral fluid support. There are, however, known risk factors which are associated with increased morbidity and mortality as a result of RSV infection. In a prospective study of RSV infections in infants and children with congenital heart disease, the mortality rate was 37%.⁸ In general, infants with underlying congenital heart disease or chronic pulmonary disease have greater morbidity and mortality from RSV infections.

With this information it is possible to formulate guidelines for therapy. On our service, use of ribavirin was considered in patients who met the following criteria: (1) Any infant or young child with a clinical diagnosis of bronchiolitis AND (2) a positive nasopharyngeal aspirate for RSV by immunofluorescence, WITH ANY OF THE FOLLOWING: (a) respiratory failure requiring mechanical ventilation, OR (b) impending respiratory failure, OR (c) underlying cardiopulmonary disease, such as congenital heart disease or bronchopulmonary dysplasia.

Summary

Ribavirin is a recently released antiviral drug with a wide spectrum of activity. When used carefully by trained personnel, it provides safe and effective treatment for RSV-induced lower respiratory tract illness. It will probably be used more widely as experience is gained. The clinical use of ribavirin is an exciting and important advance in the treatment of critically ill children.

Acknowledgement

The following people contributed to the presentation of this information: Leonard L. Sullivan, M.D. and Thomas F. Rosenberg, M.D. gave permission for use of the clinical material cited; George H. Khoury, M.D. assisted with the cardiac diagnosis in Case Two; David L. Breckbill, M.D. assisted with radiographic interpretations; Holly Alexander, Ph.D., and the microbiology laboratory personnel contributed their technical expertise; and the pediatric housestaff, nursing staff, and respiratory therapists provided carefully controlled patient management.

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***Be an effective advocate for the medical profession.
Read the KMS NEWSLETTER, page 48a, to keep
abreast of critical issues.***

Reflections

(Continued from page 50)

the aircraft manufacturers, the farm machinery manufacturers and others were not similarly faced with staggering insurance premiums? One can only surmise that it would be.

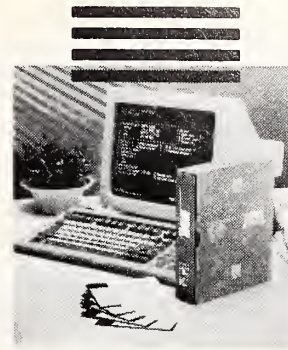
A more direct cost is the cost of the system itself; less than 40% of the premium dollar is paid to the injured party. As a method of compensating injured persons, the present tort system is highly inefficient. As a mechanism for effecting social change, it is inefficient and expensive.

Does a federal court jury in Wichita or Kansas City pause to reflect at all upon what implications its verdict will have for health care in Seward County or Barton County or elsewhere across the state? Obviously it does not, but just as obviously, such verdicts cause significant changes.

Until the excesses of the tort system can be remedied, further changes undoubtedly will occur. The creation of the Health Care Stabilization Fund served to provide insurance for the higher risk specialties. Its effectiveness has been diluted by the changes that have been found necessary to reduce its participation. Would the state be better off without a Health Care Stabilization Fund? At the present time, there is no market available to most physicians beyond relatively low limits of coverage. Dissolution of the Fund could have a profound impact upon many health care providers.

Experience has shown that, when juries are confronted with a seriously disabled plaintiff, they return verdicts approximately four times larger against certain types of defendants — including physicians — as they return against ordinary lay people for similar injuries. At some point the needs of society surpass the rights of a few to unlimited compensation. Those elements of damages not based upon economic loss are subject to great distortion and must, in such circumstances, be limited. Public opinion polls have shown that such is the wish of the majority of Kansans.

It is fortunate that the Kansas Legislature has recognized the necessity for tort change and is attempting to correct the deficiencies that presently exist in the system.



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Representatives have new addresses

Four of the five Kansas Representatives in Congress have moved to different offices. Here are the addresses where you can write to them in Washington DC 20515:

Pat Roberts, 1314 Longworth House Office Bldg.

*Jim Slattery, 1440 Longworth House Office Bldg.

*Jan Meyers, 315 Cannon House Office Bldg.

*Dan Glickman 1212 Longworth House Office Bldg.

*Robert Whittaker, 2436 Rayburn House Office Bldg.

The addresses for Senators Dole and Kassebaum and the phone numbers for all senators and representatives are correct as published on page 16 of the annual directory, the August issue of KANSAS MEDICINE.

*New address.

FAMILY/GENERAL PRACTICE

MID AMERICA KINSLEY, KS. has an excellent opportunity for family practice physician doing obstetrics. Acute care facility of 49 beds with an active swing bed program. Contact D. G. Larson, Administrator, Edwards County Hospital, P.O. Box 99, Kinsley, KS, 67547. The hospital telephone number is 316/659-3621 and my home number is 316/659-2441.

With this issue, KANSAS MEDICINE returns to its series of Kansas maps and history. After the series concludes in the spring, we will use cover art chosen from submissions of KMS members and others. Send your color slides or black and white photos for consideration to:

KANSAS MEDICINE
1300 Topeka
Topeka KS 66612

IMPAIRED PHYSICIAN PROGRAM DIRECTORY

For information concerning the Impaired Physician Program of KMS or to get help for an impaired colleague, yourself or your spouse, please contact the KMS office or the contact person in your area. All information and identities will be held in strictest confidence, and the caller need not identify himself or herself.

Elizabeth Alexander, Wichita .. 316/685-8231

**John A. Billingsley,
Olathe 913/829-3734**

Victor H. Hildyard II, Colby... 913/462-3332

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Halstead 316/835-2920**

**Kansas Medical Society,
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800/332-0156**

Alzheimer's and the Extended Patient

WHO IS the Alzheimer's patient?

With the increased incidence of Alzheimer's comes a new understanding of the importance of a comprehensive regimen that encompasses the support of the patient's spouse and other family members — the extended patient. The diagnosis of Alzheimer's can have a devastating emotional impact, and may seriously impair the family's ability to cope with the problems of finances and legal matters and the complexities of long term care.

American Medical News reported on a recent conference, "The Crisis of Alzheimer's Disease." One of the sponsors was the newly-opened Wesley Woods Geriatric Hospital, the first U.S. hospital devoted exclusively to the medical and psychiatric needs of elderly persons. Conference faculty noted that there are few comprehensive resources for Alzheimer's families and that the physicians who treat Alzheimer's lack access to multidisciplinary teams to provide adequate help to these families.

Lisa Gwyther, a specialist in support services for families of the aging, pointed out that 80% of home and community-based care of these patients is provided by family members. She highlighted some of the important ways in which the physician can provide support and care to the Alzheimer's family.

- **Diagnosis:** Choose an appropriate time and place to meet with family members and explain the prognosis and possible resources carefully and in detail. Avoid giving the impression that you want nothing more to do with the patient or his/her family.
- **Management:** Appreciate the importance of the primary care-giver. Make it a point to acquaint yourself with his/her own health situation and to structure a care program consistent with the care-giver's capabilities. Then monitor the situation in this context. Remember that this responsibility often isolates the care-giver and exacts a heavy toll in terms of mental health.
- **Disability benefits:** Support the proposed change in federal regulations that would extend benefits to Alzheimer's patients. Documentation for its necessity is being sought.
- **Institutionalization:** When it becomes obvious that it is necessary to place the patient in an institution, reassure the primary care-giver and assist in the choice of an appropriate location. It is often

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a relief to the family to feel that the physician took the responsibility for this decision; the primary consideration will often be the status of the care-giver rather than that of the patient.

- **Legal & financial services:** Since these are critical factors in the care of the Alzheimer's patient, you need to cooperate with the family in resolving the inevitable dilemmas. Support appropriate legal proceedings such as certification of incompetency, power-of-attorney, and establishment of trust funds.

The prognosis for improvement in the availability of adequate long-term care for Alzheimer's patients is as bleak as for the disease itself. As the aging population continues to increase, there will be a corresponding increase in the pressures on patients' families to meet the physical, emotional, and financial demands of this affliction.

"When we take on an Alzheimer's patient," concluded Alan Stoudemire, M.D., conference organizer, "we must stand ready to provide continuing support to the patient and, more important, to the family."



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Amer. Photog. [Special: 8 iss.]	5.98	5.98			Health [Special: 9 issues]	8.97	8.97			#PRACTICAL HOMEOWNER	9	12.97	6.50	9.97
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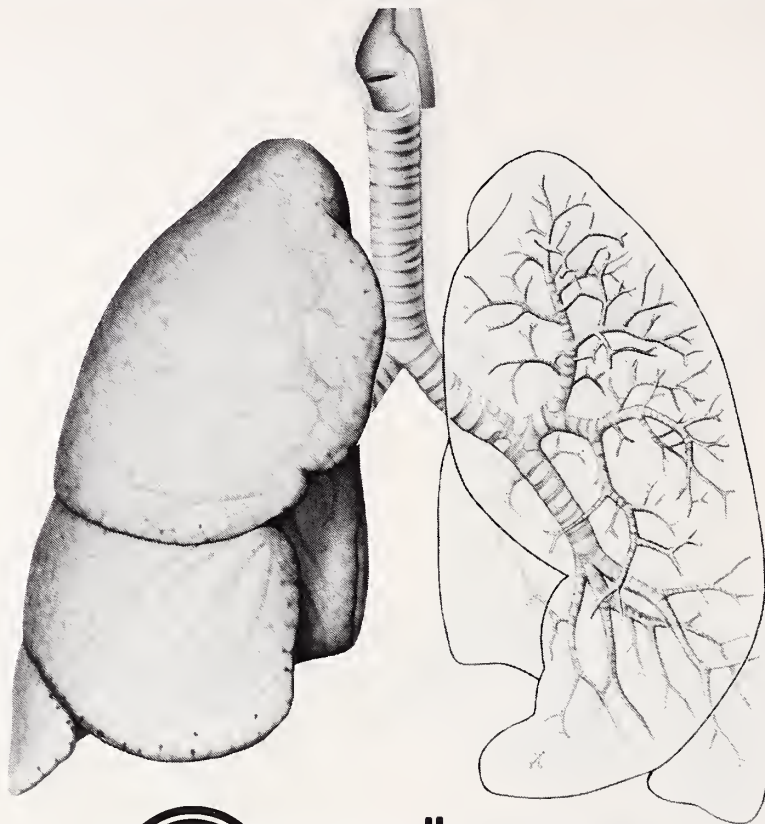
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Note: Ceclor[®] is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Ceclor[®] (cefacor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Contraindications: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-

associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor

penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

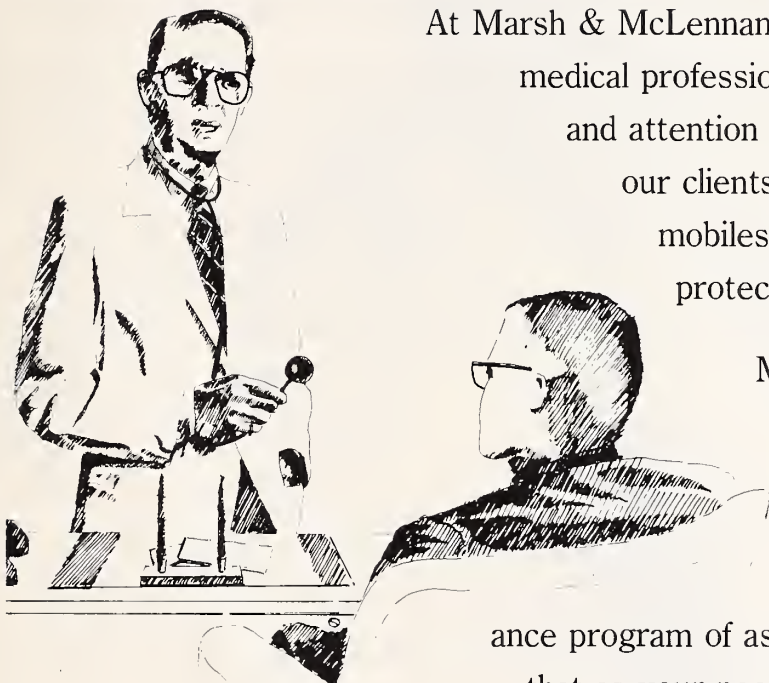
Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest[®] tablets but not with Tes-tape[®] (glucose enzymatic test strip, Lilly)

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 Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285
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A SPECIAL CONFIDENCE



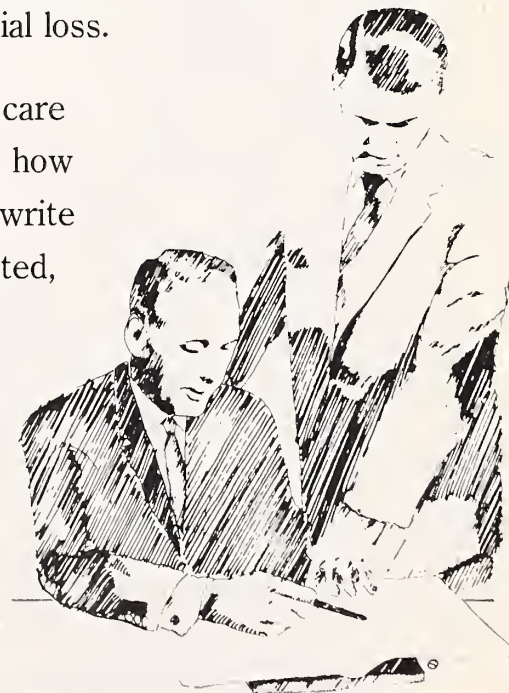
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Continuing Medical Education

The 1976 Kansas Legislature enacted a law requiring continuing medical education as a requisite to relicensure in Kansas. HB-2723 provides that, "From and after July 1, 1978, the Kansas State Board of Healing Arts shall require every licensee to submit with the renewal application evidence of satisfactory completion of a program of continuing education required by the Board." Physicians not in the active practice of the healing arts in the State of Kansas may be exempted from the continuing medical education requirements for relicensure by signing an affidavit furnished by the Kansas State Board of Healing Arts. The following is a description of the CME requirements established by the Board, and an explanation of how to comply with the requirements.

As a basic requirement, the Board adopted the CME requirements of the Kansas Medical Society, which is the attainment of the American Medical Association "Physician's Recognition Award." The basic criterion for the PRA is 150 hours of educational experience over a three-year period. The educational activities are described in six separate categories. Below is a brief description of each category and the maximum number of hours that can be obtained in each category:

	<i>Credit Hours Limit</i>
Category 1 — CME activities with accredited sponsorship (60 hours required)	no limit
Category 2 — CME activities with non-accredited sponsorship	90 hrs.

Completion of AMA-PRA satisfies the requirement established by the Board. Because relicensure is on a yearly basis, and the PRA is on a three-year basis, a physician need only have a valid PRA in effect to be in compliance with the requirements of the Board.

Additionally, completion of the CME certification programs of any of the following organizations also constitutes compliance with the requirements of the Board:

- American Academy of Dermatology (AAD)
- American Academy of Family Physicians (AAFP)
- American Association of Neurological Surgeons/
Congress of Neurological Surgeons (AANS/CNS)
- American College of Obstetricians & Gynecologists (ACOG)
- American College of Preventive Medicine (ACPM)
- American Psychiatric Association (APA)
- American Society of Clinical Pathologists/
College of American Pathologists (ASCP/CAP)
- American Society of Colon & Rectal Surgeons (ASCRS)
- American Society of Plastic & Reconstructive Surgeons (ASPRS)
- American Urological Association, Inc. (AUA)

If you satisfy the requirements of any of the above organizations, you need *not* apply for the "Physician's Recognition Award."

If you do not qualify for the specialty organization programs listed above, you must apply directly to the AMA for the "Physician's Recognition Award." Upon receipt of the award, the AMA will notify the Kansas Medical Society that you have completed the requirement.

Questions concerning CME requirement can be directed to the Board or the Kansas Medical Society. The addresses of each are as follows:

The Kansas State Board of Healing Arts
503 Kansas Avenue
Topeka, KS 66603
Telephone: (913) 296-7413

The Kansas Medical Society
1300 Topeka Boulevard
Topeka, KS 66612
Telephone: (913) 235-2383

Each individual physician is responsible for recording his own hours of attendance at postgraduate courses. The credit hours should be recorded on the AMA Physician's Recognition Award application form when 150 hours are accumulated. The application form should then be mailed directly to the AMA, 535 North Dearborn, Chicago, IL 60610.



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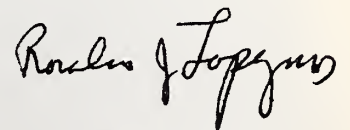
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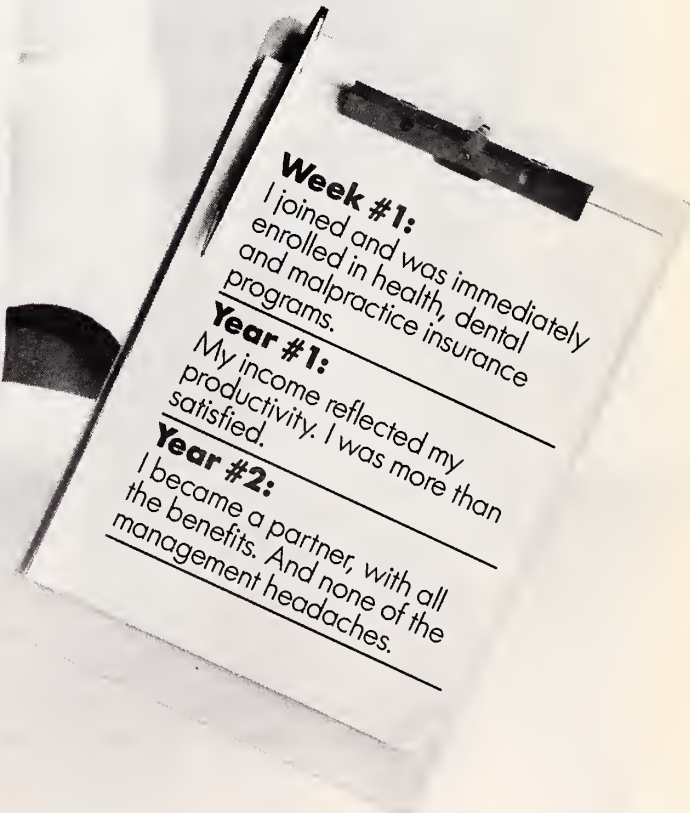
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Asthma

(Continued from page 47)

wheezing may help the physician to make the diagnosis. The diagnosis can be confirmed by radiologic evidence which is still the "gold standard." Ultrasound examination is advocated by a few investigators, but remains an unreliable diagnostic tool. CAT scan is a very reliable radiographic test — especially with contrast — as it can readily differentiate the amount of mucosal edema and fluid. However, CAT scan is costly, and despite its accuracy is therefore seldom utilized.⁷

Management of sinusitis complicating asthma consists of three major modalities: antimicrobial therapy, decongestion and improvement in mobilization of purulent material, and management of asthma. Selection, length, and appropriate dosage of antibiotics are of major importance. Amoxicillin, trimethoprim-sulfa, and cephalosporins are effective for treatment of sinusitis. Tetracycline, doxycycline, or minocycline can be used in adolescents. Antibiotic therapy should be continued for from two to four weeks despite apparent clinical resolution of symptoms. Appropriate dosages are necessary, regardless of the length of therapy.⁸ Clinical resolution of symptoms can be seen with inadequate or sub-therapeutic doses, but recurrence is common.⁸

In addition to clearing the infection, it is important to facilitate drainage of muco-purulent material and decrease edema around the sinus ostia. Oral decongestants and mucolytic agents combined (*i.e.*

pseudo-ephedrine and guaifenesin) and topical nasal decongestants (1% phenylephrine) will facilitate drainage.⁹ Asthma should be managed with adequate rest, oral and inhaled bronchodilators, oral and inhaled steroids, and ample humidification. The patient should be assessed often to assure progressive recovery. If there is no improvement with management, a change of antibiotic, nasal irrigation, or lavage may be of help.¹⁰

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A list of additional articles on this topic is available from Dr. Neiburger, Division of Allergy-Immunology, UKSM-KC 39th & Rainbow Blvd., Kansas City KS 66103.



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INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of Inderal has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. Inderal has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, Inderal also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: Inderal LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior

to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSEAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal tablets to Inderal LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg for mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION — Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS — Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE — Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS — 80-160 mg Inderal LA once daily.

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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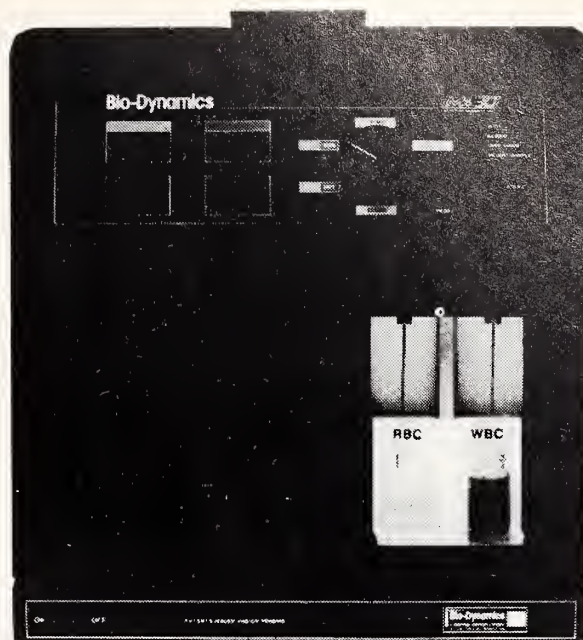
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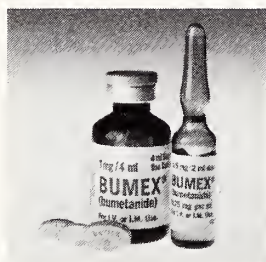
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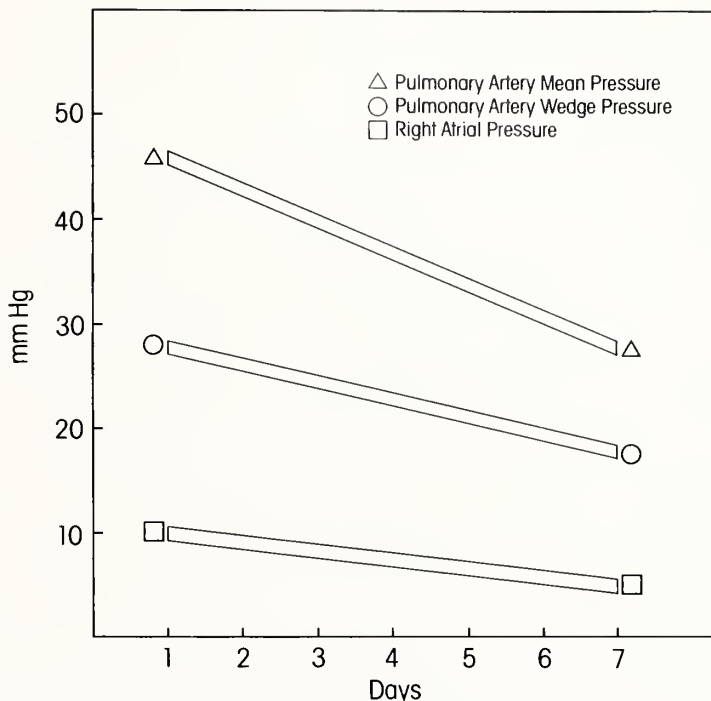
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WARNINGS: Dose should be adjusted to patient's needs. Excessive doses or too frequent administration can lead to profound water loss, electrolyte depletion, dehydration, reduction in blood volume and circulatory collapse with the possibility of vascular thrombosis and embolism, particularly in elderly patients.

Prevention of hypokalemia requires particular attention in patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis and ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, certain diarrheal states, or other states where hypokalemia is thought to represent particular added risks to the patients.

In patients with hepatic cirrhosis and ascites, sudden alterations of electrolyte balance may precipitate hepatic encephalopathy and coma. Treatment in such patients is best initiated in the hospital with small doses and careful monitoring of the patient's clinical status and electrolyte balance. Supplemental potassium and/or spironolactone may prevent hypokalemia and metabolic alkalosis in these patients.

In cats, dogs and guinea pigs, Bumex has been shown to produce ototoxicity. Since Bumex is about 40 to 60 times as potent as furosemide, it is anticipated that blood levels necessary to produce ototoxicity will rarely be achieved. The potential for ototoxicity increases with intravenous therapy, especially of high doses.

Patients allergic to sulfonamides may show hypersensitivity to Bumex.

PRECAUTIONS: Measure serum potassium periodically and add potassium supplements or potassium-sparing diuretics, if necessary. Periodic determinations of other electrolytes are advised in patients treated with high doses or for prolonged periods, particularly in those on low salt diets. Hyperuricemia may occur. Reversible elevations of the BUN and creatinine may occur, especially with dehydration and in patients with renal insufficiency. Bumex may increase urinary calcium excretion.

Possibility of effect on glucose metabolism exists. Periodic determinations of blood sugar should be done, particularly in patients with diabetes or suspected latent diabetes.

Patients should be observed regularly for possible occurrence of blood dyscrasias, liver damage or idiosyncratic reactions.

Especially in presence of impaired renal function, use of parenterally administered Bumex should be avoided in patients to whom aminoglycoside antibiotics are also being given, except in life-threatening conditions.

Drugs with nephrotoxic potential and bumetanide should not be administered simultaneously. Since lithium reduces renal clearance and adds a high risk of lithium toxicity, it should not be given with diuretics.

Probenecid should not be administered concurrently with Bumex.

Concurrent therapy with indomethacin not recommended.

Bumex may potentiate the effects of antihypertensive drugs, necessitating reduction in dosage.

Interaction studies in humans have shown no effect on digoxin blood levels.

Interaction studies in humans have shown Bumex to have no effect on warfarin metabolism or on plasma prothrombin activity.

Pregnancy: Bumex should be given to a pregnant woman only if the potential benefit justifies the potential risk to the fetus.

Bumetanide may be excreted in breast milk.

Pediatric Use: Safety and effectiveness below age 18 not established.

ADVERSE REACTIONS: Muscle cramps, dizziness, hypotension, headache and nausea, and encephalopathy (in patients with preexisting liver disease).

Less frequent clinical adverse reactions are weakness, impaired hearing, rash, pruritus, hives, electrocardiogram changes, abdominal pain, arthritic pain, musculoskeletal pain and vomiting. Other clinical adverse reactions are vertigo, chest pain, ear discomfort, fatigue, dehydration, sweating, hyperventilation, dry mouth, upset stomach, renal failure, asterixis, itching, nipple tenderness, diarrhea, premature ejaculation and difficulty maintaining an erection.

Laboratory abnormalities reported are hyperuricemia, azotemia, hyperglycemia, increased serum creatinine, hypochloremia, hypokalemia, hyponatremia, and variations in CO₂ content, bicarbonate, phosphorus and calcium. Although manifestations of the pharmacologic action of Bumex, these conditions may become more pronounced by intensive therapy.

Diuresis induced by Bumex may also rarely be accompanied by changes in LDH, total serum bilirubin, serum proteins, SGOT, SGPT, alkaline phosphatase, cholesterol, creatinine clearance, deviations in hemoglobin, prothrombin time, hematocrit, platelet counts and differential counts. Increases in urinary glucose and urinary protein have also been seen.

DOSAGE AND ADMINISTRATION:

Oral Administration: The usual total daily dosage is 0.5 to 2.0 mg and in most patients is given as a single dose.

Parenteral Administration: Administer to patients (IV or IM) with GI absorption problem or who cannot take oral. The usual initial dose is 0.5 to 1 mg given over 1 to 2 minutes. If insufficient response, a second or third dose may be given at 2 to 3 hour intervals up to a maximum of 10 mg a day.

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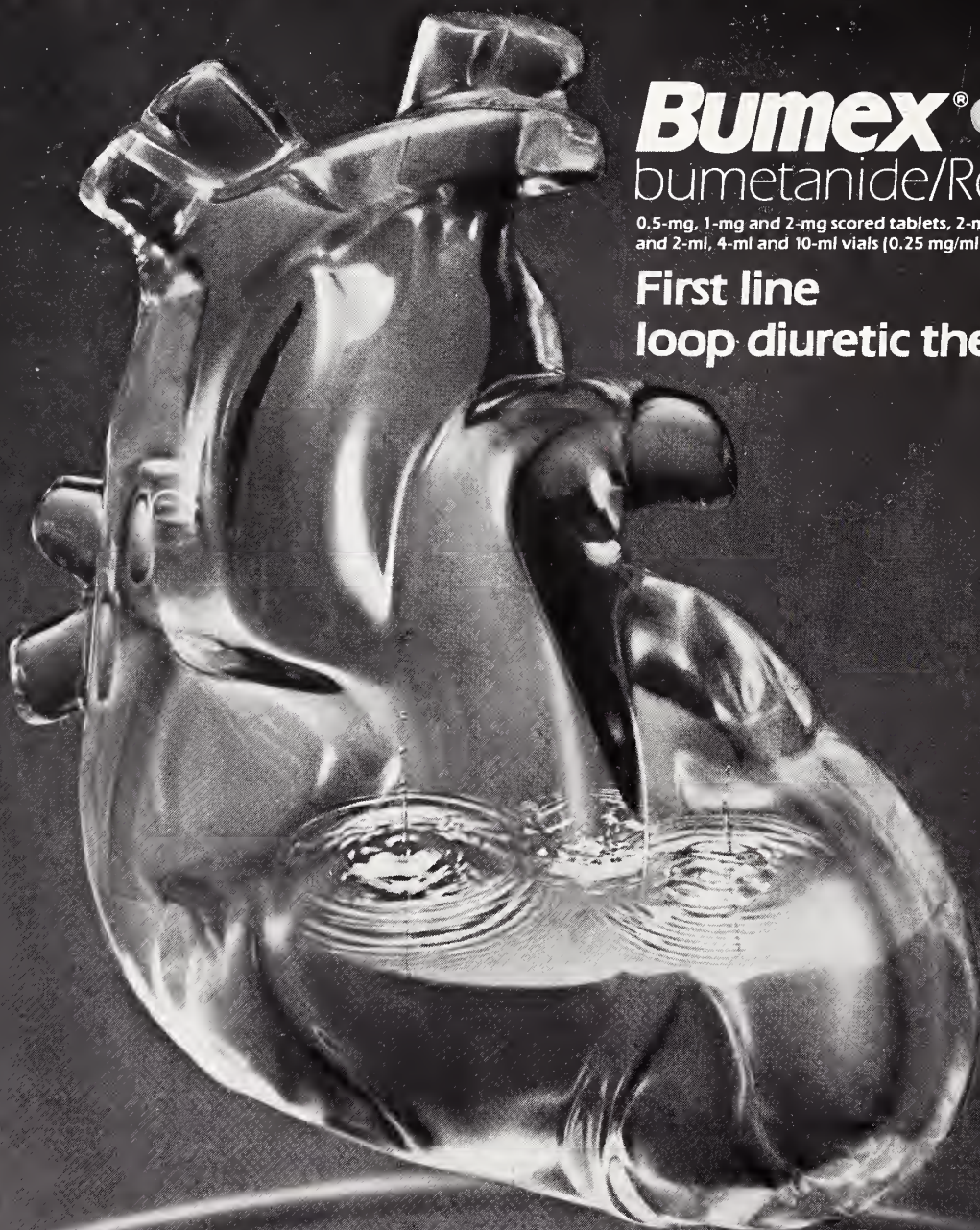
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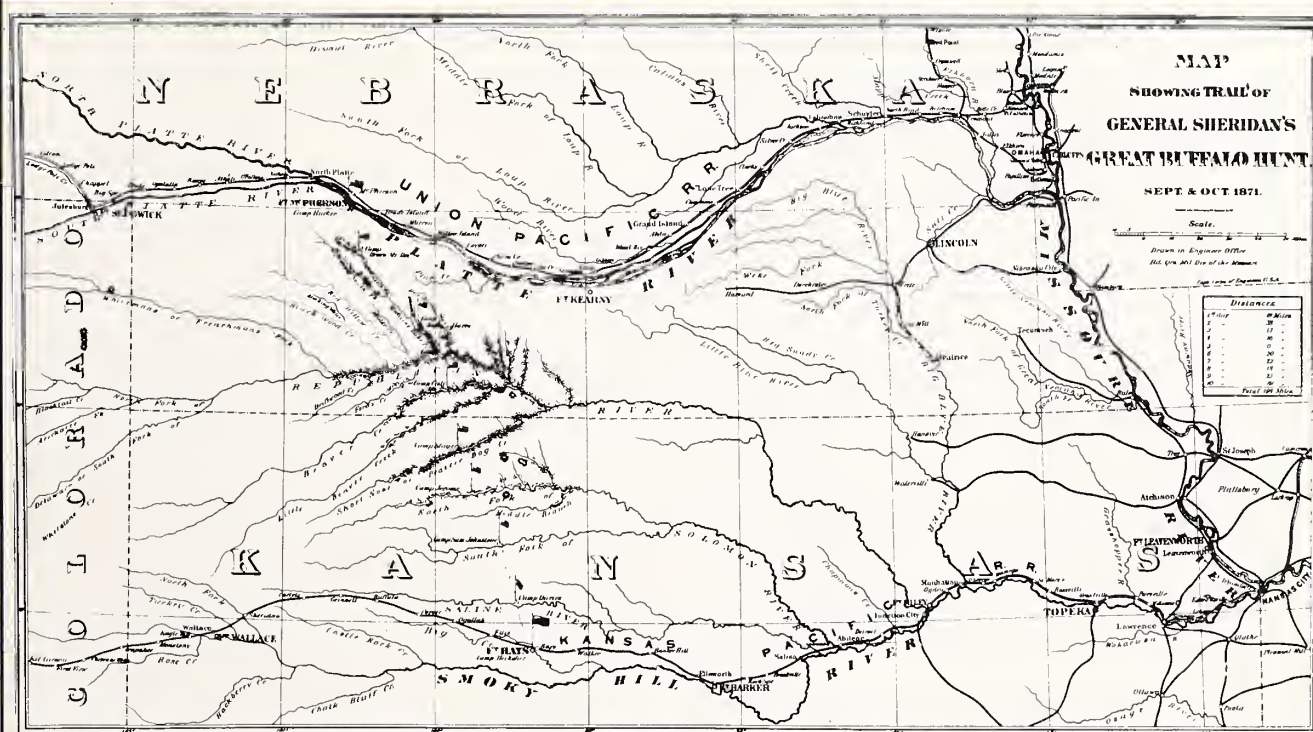
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KANSAS MEDICINE

Volume 88, Number 3, March 1987 ISSN 8755-0059



A "royal buffalo hunt" for Russian Grand Duke Alexis was staged in 1872 by Gen. Philip Sheridan. Such additional notables as Gen. George A. Custer and Buffalo Bill Cody also participated, and under their tutelage the young prince enjoyed a week of

riding, shooting and Indian dances on the Plains of Nebraska, Colorado and Kansas. The curious map reproduced here shows how Gen. Sheridan combined army duty with a sportsman's pleasures in touring western Kansas army posts in the fall of 1871.

Cover story — page 69

Penicillin Allergy Update	78
Epilepsy and Driving Privileges	81
Total Spinal Anesthesia	84
Evaluation of Clinical Immunologic Tests	85
KMS Newsletter	84a

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KANSAS MEDICINE

• The Journal Of The Kansas Medical Society •

Volume 88, Number 3, March 1987

Contents

Scientific Articles

- Penicillin Allergy Update — J. M. Aggarwal, M.D. and J. B. Neiburger, M.D., Kansas City, Kansas
Detailed knowledge of risk factors and protocols in penicillin treatment will guard against life threatening reactions 78
- Epilepsy and Driving Privileges — David J. Walsh, M.D., Kansas City, Kansas
Under controlled conditions, Kansas law provides some epileptics the privilege of a driver's license 81
- Total Spinal Anesthesia — A Complication of Intercostal Nerve Block — Doug Friesen, M.D. and R. H. Robinson, M.D., Wichita
Total spinal anesthesia is a rare complication following intercostal nerve block for alleviation of post-operative pain. 84

Current Comment

- Evaluation of Clinical Immunologic Tests — Nabih I. Abdou, M.D., Ph.D.; Ronsuke Suenaga, M.D. and Nancy Becker, M.D., Kansas City, Kansas 85

Miscellaneous

- AMA Initiative on Adolescent Health 72
- A Personal View — A Response: *If Not the AMA, Who?* — William J. Reals, M.D., Wichita 66
- A Personal View: *And We Shall Be Led By Hindsight* — John Rand Neuenschwander, M.D., Hoxie 98
- Classified Advertisements 100
- Correction 96
- Council Meeting 93
- Cover Story 69
- Editorial Comment: *Locum Tenens* 89
- Impaired Physician Program Resource List 77
- Information for Authors 92
- KMS Newsletter 84a
- Medicina et Lex: *Chiropractors and Staff Privileges* — Wayne T. Stratton, J.D., Topeka 90
- Nominating Committee Report 71
- Physician Directory 74
- President's Message 88

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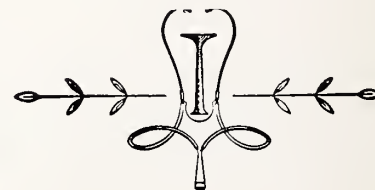
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Saturday, May 2

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Sunday, May 3

KMS Second House of Delegates, Council Meeting.

Note: Price discounts are available for those who pay prior to April 15; Register NOW and SAVE!



A PERSONAL VIEW

If Not the AMA, Who?

WILLIAM J. REALS, M.D.,* *Wichita*

IN A THOUGHTFUL personal view, "Unification Revisited," (KANSAS MEDICINE, February 1987) Dr. Leitch raises some very important organizational issues that require full discussion by KMS members.

Over the past 30 years, the house of medicine has been badly fragmented by the development of numerous specialty societies, growing concern of the individual physician for his/her practice, and increasing challenges from government at all levels — principally the federal government. While each specialty society speaks for a particular disease, mode of practice or part of the human body, only one organization — the AMA — represents *all* physicians nationally, members as well as non-members, in Congress and the 50 states.

Today, as we consider the issue of unification, we should realize that the AMA is a minority medical society consisting of half the nation's physicians, a point well known to senators, congressmen, and bureaucrats who propose more and more restrictive legislation. Despite this position, the AMA is striving to increase its membership and to become the majority voice of American medicine to the Congress, the administration, and the public. The KMS joined in this effort by voting for unification at the 1985 annual meeting.

I should like to raise the question, if not the AMA representing physicians in the matter of DRGs, then who? If the AMA does not have a major role in

accreditation of medical schools and residency programs, then who? What could the Kansas Medical Society accomplish without the AMA vis-a-vis federal programs, state licensure issues, continuing medical education, quality assurance, the JCAH, and a host of other critical issues facing all of us today?

Perhaps the most critical issue for physicians is DRGs. At this writing, a proposal is before Congress to impose DRGs on anesthesiologists, pathologists, and radiologists. While these three specialties represent a small percentage of the total physician population, it is but the beginning of DRGs for all physicians. Consequently, fees for Medicare patients will be paid to hospitals, and physician reimbursement will be decided between the hospital and physician. Could KMS fight this proposal alone in Congress? The AMA has been in the forefront of fierce opposition to physician DRGs and, at the moment, chances are improving that the issue will be defeated.

Finally, if the AMA is to represent medicine, it should represent *all* physicians. Those of us who have been longtime loyal AMA members and paid dues over the years are providing the financial support the organization needs to maintain its legislative role in Washington as well as the many other roles it plays. Those who do not join are enjoying a free ride, benefitting but not paying. Can the profession long survive in this manner?

Many years ago Ben Franklin said, "We must all hang together, or we will assuredly hang separately." The United States was born out of representation to a national congress which is not much different from the AMA system of delegates to the AMA House of Delegates. We need to remain unified. We need your support and dues, and we need a strong AMA.

Again, if not the AMA, who?

For another "Personal View," see page 98.

* KMS Delegate to the AMA; Dean, UKSM-Wichita; former KMS President.

Editor's Note: This article was prepared by Dr. Reals in response to the "Personal View" presented in the February issue of KANSAS MEDICINE by David A. Leitch, M.D., critical of unification and the way it was implemented. In printing original opinions as well as responses such as this, we intend to offer our readers the opportunity to express varying opinions in order to encourage a full range of thoughts on medical problems of the day. Editing (as in all "Personal View" contributions) is defined by space requirements and appropriate textual control within legal limits, and the opinions do not necessarily represent those of KANSAS MEDICINE or the Kansas Medical Society.



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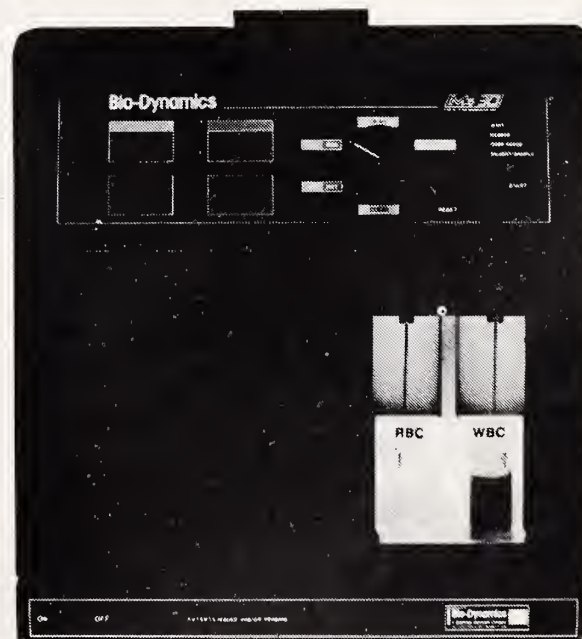
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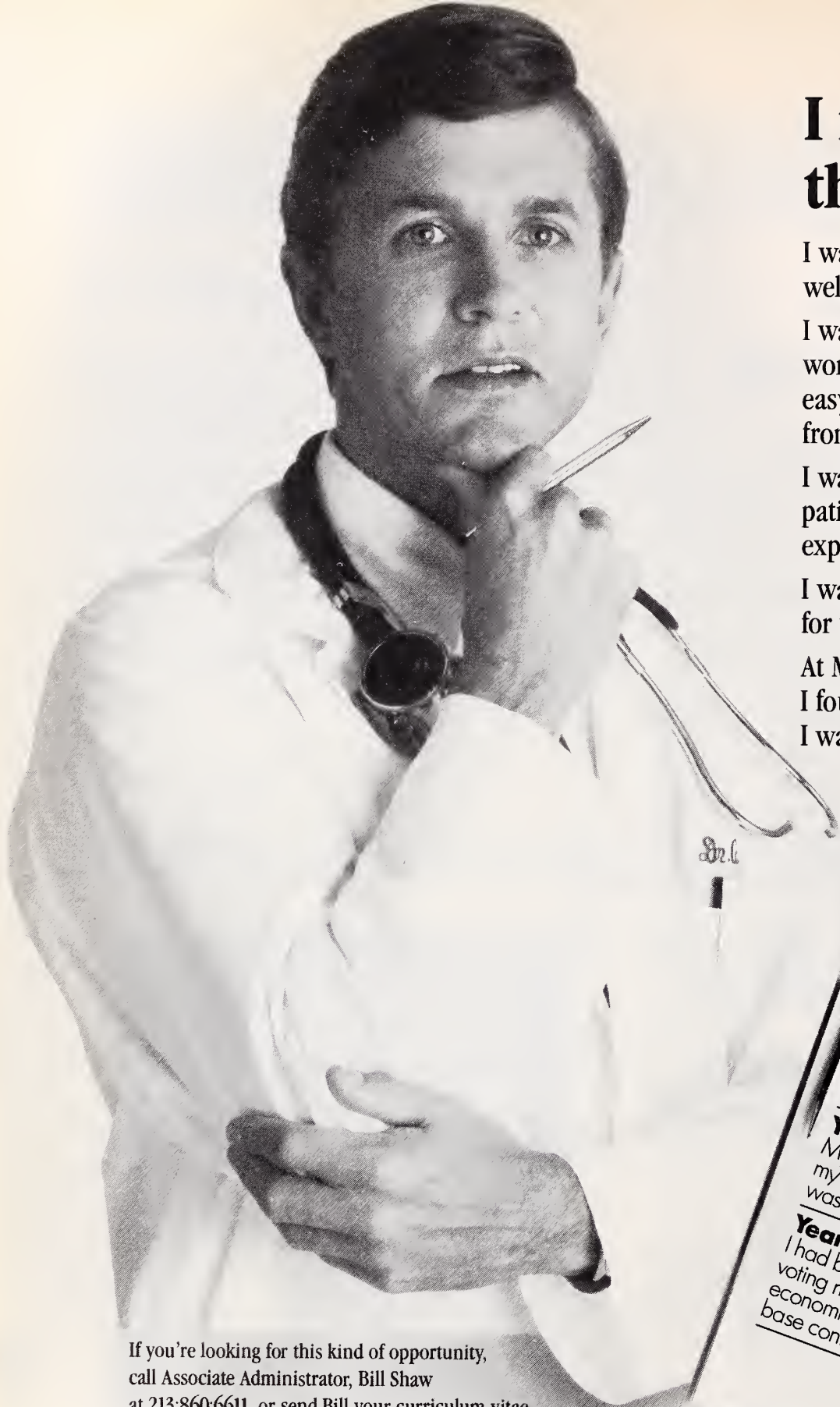
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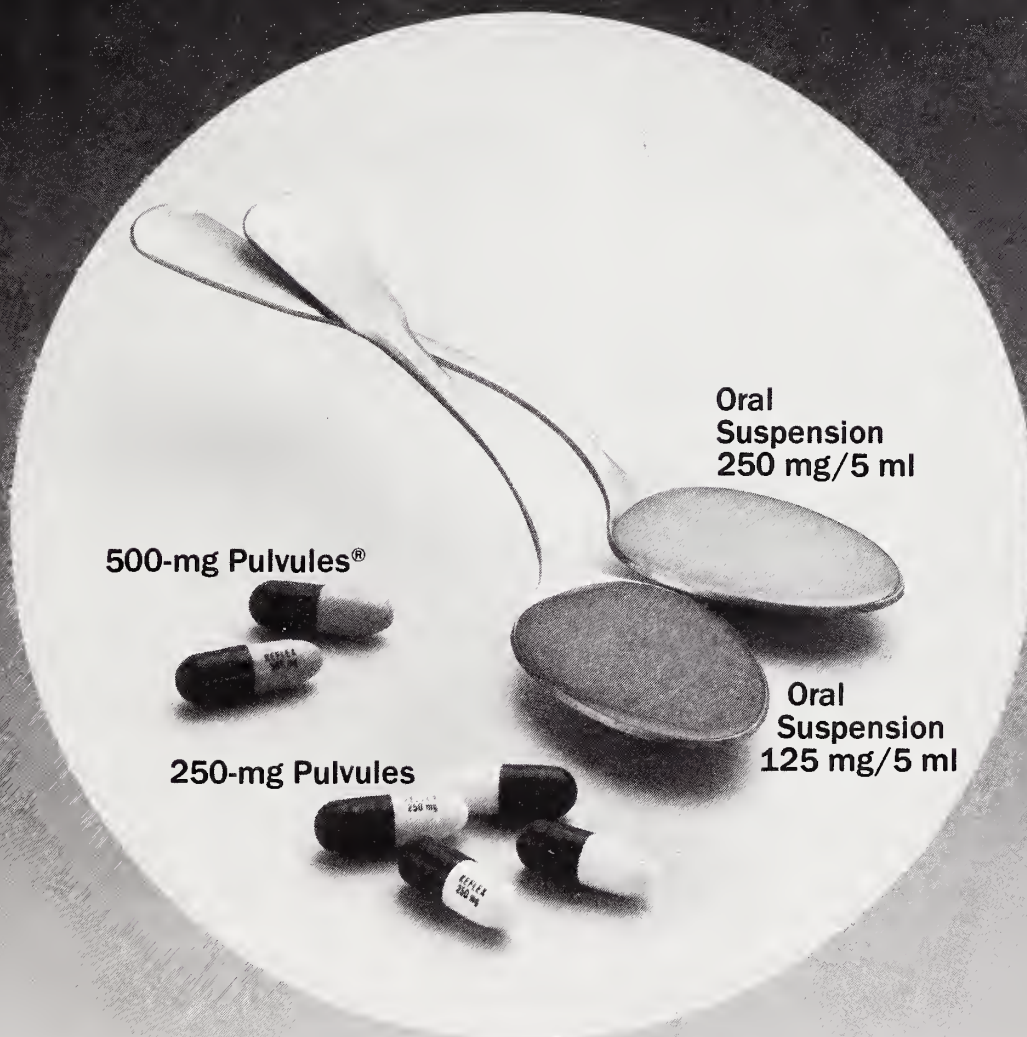
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1. Sachs R, Frank M, Fishman SK: Overview of clinical experience with glipizide. In *Glipizide: A Worldwide Review* Princeton, NJ, Excerpta Medica, 1984, pp 163-172.

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Brief Summary of Prescribing Information

INDICATIONS AND USAGE: GLUCOTROL is indicated as an adjunct to diet for the control of hyperglycemia in patients with non-insulin-dependent diabetes mellitus (NIDDM, type II) after an adequate trial of dietary therapy has proved unsatisfactory.

CONTRAINDICATIONS: GLUCOTROL is contraindicated in patients with known hypersensitivity to the drug or with diabetic ketoacidosis, with or without coma, which should be treated with insulin.

SPECIAL WARNING ON INCREASED RISK OF CARDIOVASCULAR MORTALITY: The administration of oral hypoglycemic drugs has been reported to be associated with increased cardiovascular mortality as compared to treatment with diet alone or diet plus insulin. This warning is based on the study conducted by the University Group Diabetes Program (UGDP), a long-term prospective clinical trial designed to evaluate the effectiveness of glucose-lowering drugs in preventing or delaying vascular complications in patients with non-insulin-dependent diabetes. The study involved 823 patients who were randomly assigned to one of four treatment groups (*Diabetes*, 19, supp. 2:747-830, 1970).

UGDP reported that patients treated for 5 to 8 years with diet plus a fixed dose of tolbutamide (1.5 grams per day) had a rate of cardiovascular mortality approximately 2 1/2 times that of patients treated with diet alone. A significant increase in total mortality was not observed, but the use of tolbutamide was discontinued based on the increase in cardiovascular mortality, thus limiting the opportunity for the study to show an increase in overall mortality. Despite controversy regarding the interpretation of these results, the findings of the UGDP study provide an adequate basis for this warning. The patient should be informed of the potential risks and advantages of GLUCOTROL and of alternative modes of therapy.

Although only one drug in the sulfonylurea class (tolbutamide) was included in this study, it is prudent from a safety standpoint to consider that this warning may also apply to other oral hypoglycemic drugs in this class, in view of their close similarities in mode of action and chemical structure.

PRECAUTIONS: Renal and Hepatic Disease: The metabolism and excretion of GLUCOTROL may be slowed in patients with impaired renal and/or hepatic function. Hypoglycemia may be prolonged in such patients should it occur.

Hypoglycemia: All sulfonylureas are capable of producing severe hypoglycemia. Proper patient selection, dosage, and instructions are important to avoid hypoglycemia. Renal or hepatic insufficiency may increase the risk of hypoglycemic reactions. Elderly, debilitated or malnourished patients and those with adrenal or pituitary insufficiency are particularly susceptible to the hypoglycemic action of glucose-lowering drugs. Hypoglycemia may be difficult to recognize in the elderly or people taking beta-adrenergic blocking drugs. Hypoglycemia is more likely to occur when caloric intake is deficient, after severe or prolonged exercise, when alcohol is ingested, or when more than one glucose-lowering drug is used.

Loss of Control of Blood Glucose: A loss of control may occur in diabetic patients exposed to stress such as fever, trauma, infection or surgery. It may then be necessary to discontinue GLUCOTROL and administer insulin.

Laboratory Tests: Blood and urine glucose should be monitored periodically. Measurement of glycosylated hemoglobin may be useful.

Information for Patients: Patients should be informed of the potential risks and advantages of GLUCOTROL, of alternative modes of therapy, as well as the importance of adhering to dietary instructions, of a regular exercise program, and of regular testing of urine and/or blood glucose. The risks of hypoglycemia, its symptoms and treatment, and conditions that predispose to its development should be explained to patients and responsible family members. Primary and secondary failure should also be explained.

Drug Interactions: The hypoglycemic action of sulfonylureas may be potentiated by certain drugs including non-steroidal anti-inflammatory agents and other drugs that are highly protein bound, salicylates, sulfonamides, chloramphenicol, probenecid, coumarins, monoamine oxidase inhibitors, and beta adrenergic blocking agents. *In vitro* studies indicate that GLUCOTROL binds differently than tolbutamide and does not interact with salicylate or dicumarol. However, caution must be exercised in extrapolating these findings to a clinical situation. Certain drugs tend to produce hyperglycemia and may lead to loss of control, including the thiazides and other diuretics, corticosteroids, phenothiazines, thyroid products, estrogens, oral contraceptives, phenytoin, nicotinic acid, sympathomimetics, calcium channel blocking drugs, and isoniazid. A potential interaction between oral miconazole and oral hypoglycemic agents leading to severe hypoglycemia has been reported. Whether this interaction also occurs with the intravenous, topical, or vaginal preparations of miconazole is not known.

Carcinogenesis, Mutagenesis, Impairment of Fertility: A 20-month study in rats and an 18-month study in mice at doses up to 75 times the maximum human dose revealed no evidence of drug-related carcinogenicity. Bacterial and *in vivo* mutagenicity tests were uniformly negative. Studies in rats of both sexes at doses up to 75 times the human dose showed no effects on fertility.

Pregnancy: Pregnancy Category C: GLUCOTROL (glipizide) was found to be mildly fetotoxic in rat reproductive studies at all dose levels (5-50 mg/kg). This fetotoxicity has been similarly noted with other sulfonylureas, such as tolbutamide and tolazamide. The effect is perinatal and believed to be directly related to the pharmacologic (hypoglycemic) action of GLUCOTROL. In studies in rats and rabbits no teratogenic effects were found. There are no adequate and well controlled studies in pregnant women. GLUCOTROL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Because recent information suggests that abnormal blood glucose levels during pregnancy are associated with a higher incidence of congenital abnormalities, many experts recommend that insulin be used during pregnancy to maintain blood glucose levels as close to normal as possible.

Nonteratogenic Effects: Prolonged severe hypoglycemia has been reported in neonates born to mothers who were receiving a sulfonylurea drug at the time of delivery. This has been reported more frequently with the use of agents with prolonged half-lives. GLUCOTROL should be discontinued at least one month before the expected delivery date.

Nursing Mothers: Since some sulfonylurea drugs are known to be excreted in human milk, insulin therapy should be considered if nursing is to be continued.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: In controlled studies, the frequency of serious adverse reactions reported was very low. Of 702 patients, 11.8% reported adverse reactions and in only 1.5% was GLUCOTROL discontinued.

Hypoglycemia: See PRECAUTIONS and OVERDOSAGE sections.

Gastrointestinal: Gastrointestinal disturbances, the most common, were reported with the following approximate incidence: nausea and diarrhea, one in 70; constipation and gastralgia, one in 100. They appear to be dose-related and may disappear on division or reduction of dosage. Cholestatic jaundice may occur rarely with sulfonylureas. GLUCOTROL should be discontinued if this occurs.

Dermatologic: Allergic skin reactions including erythema, morbilliform or maculopapular eruptions, urticaria, pruritus, and eczema have been reported in about one in 70 patients. These may be transient and may disappear despite continued use of GLUCOTROL; if skin reactions persist, the drug should be discontinued. Porphyrria cutanea tarda and photosensitivity reactions have been reported with sulfonylureas.

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia, hemolytic anemia, aplastic anemia, and pancytopenia have been reported with sulfonylureas.

Metabolic: Hepatic porphyria and disulfiram-like alcohol reactions have been reported with sulfonylureas. Clinical experience to date has shown that GLUCOTROL has an extremely low incidence of disulfiram-like reactions.

Endocrine Reactions: Cases of hyponatremia and the syndrome of inappropriate antidiuretic hormone (SIAOH) secretion have been reported with this and other sulfonylureas.

Miscellaneous: Dizziness, drowsiness, and headache have been reported in about one in fifty patients treated with GLUCOTROL. They are usually transient and seldom require discontinuance of therapy.

OVERDOSAGE: Overdosage of sulfonylureas including GLUCOTROL can produce hypoglycemia. If hypoglycemic coma is diagnosed or suspected, the patient should be given a rapid intravenous injection of concentrated (50%) glucose solution. This should be followed by a continuous infusion of a more dilute (10%) glucose solution at a rate that will maintain the blood glucose at a level above 100 mg/dL. Patients should be closely monitored for a minimum of 24 to 48 hours since hypoglycemia may recur after apparent clinical recovery. Clearance of GLUCOTROL from plasma would be prolonged in persons with liver disease. Because of the extensive protein binding of GLUCOTROL (glipizide), dialysis is unlikely to be of benefit.

DOSE AND ADMINISTRATION: There is no fixed dosage regimen for the management of diabetes mellitus with GLUCOTROL; in general, it should be given approximately 30 minutes before a meal to achieve the greatest reduction in postprandial hyperglycemia.

Initial Dose: The recommended starting dose is 5 mg before breakfast. Geriatric patients or those with liver disease may be started on 2.5 mg. Dosage adjustments should ordinarily be in increments of 2.5-5 mg, as determined by blood glucose response. At least several days should elapse between titration steps.

Maximum Dose: The maximum recommended total daily dose is 40 mg.

Maintenance: Some patients may be effectively controlled on a once-a-day regimen, while others show better response with divided dosing. Total daily doses above 15 mg should ordinarily be divided.

HOW SUPPLIED: GLUCOTROL is available as white, dye-free, scored diamond-shaped tablets imprinted as follows: 5 mg tablet—Pfizer 411 (NOC 5 mg 0049-4110-66) Bottles of 100; 10 mg tablet—Pfizer 412 (NOC 10 mg 0049-4120-65) Bottles of 100.

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Cover Story

Map: "General Sheridan's Great Buffalo Hunt," reproduced from Baughman's *Kansas in Maps*, courtesy of the *Kansas State Historical Society*.

Present day advocates of ecology and animal conservation would have been scandalized and indeed, some voices — editorial and personal — were raised against it. But they were of little effect, and in the mid-1800s, the buffalo hunt was a generally honored institution.

The buffalo could hardly be called "sporting" animals. Their bulk, tempers, and desperate evasive actions made them formidable on direct encounter, but they had no sporting canniness to offset a reasonably good marksman on a well trained "buffalo horse." One invitation to indiscriminate killing of the animals was the size of the herds — estimated at more than 30,000,000 animals at one time — making it easy to believe the supply was inexhaustible. Another factor was the military which, despite various demands on it, had considerable time on its hands and buffalo hunting was, for them (especially the officers) and visiting dignitaries, a prime activity.

No military figure was more dedicated to hunting buffalo than General Phil Sheridan whose route on one occasion is shown in the cover map. He arranged the well-publicized hunt in honor of Duke Alexis of Russia in 1872. The young state, delighted by the visit of a prince and international sportsman, provided a hunt that killed some 200 buffalo. The Duke was then feted in Topeka by the Legislature, which would shortly pass a buffalo protection act, and Governor James Harvey, who would veto it.

The railroads played their part, too, making up special trains to carry hunters to the animals and publicizing the excursions and the fact that said hunters could shoot from the comfort and safety of the trains. Strongly affected, too, were the natives who had for ages depended on the animals for food, clothing and shelter, taking only the numbers necessary for their essential use. Confined to their designated areas, depleted by the white man's encroachment, having minimal agrarian skills (and less interest), and seeing the rotting carcasses after the hunters took only the hides, their loss was all the more grievous and accounted for no small part of the Indians' bitterness.

By the mid-1870s, the herds were seriously depleted as the immigration tide moved west bringing roads, fences, and farms. Supply diminished but so did the demand, rendering the buffalo a novelty to be displayed in Wild West shows or ranches — even threatened with extinction. As the latter realization grew, so did conservation efforts. How the current supply and demand compare is unknown but buffalo meat has again become available at times in the butcher's showcase at prices that would make the 19th Century Indians go on the warpath. — D.E.G.



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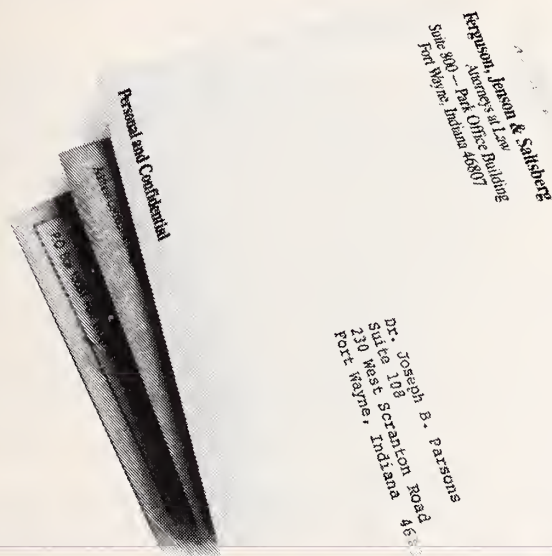
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Nominating Committee Report

The KMS Nominating Committee has submitted the following slate of candidates for offices for the election to be held at the annual meeting April 30-May 3, 1987, in Manhattan:

PRESIDENT: Donald W. Hatton, M.D., Lawrence
PRESIDENT ELECT: Terry L. Poling, M.D., Wichita

FIRST VICE PRESIDENT: Alex Scott, M.D., Junction City

SECOND VICE PRESIDENT: Francis R. Applegate, Jr., M.D., Hays; Arthur D. Snow, Jr., M.D., Shawnee Mission; Roger D. Warren, M.D., Hanover

CONSTITUTIONAL SECRETARY: Katherine Pennington, M.D., Wichita

TREASURER: Larry Rotert, M.D., Topeka; Donald R. Brada, Hutchinson

SPEAKER: Larry R. Anderson, M.D., Wellington; Ivan E. Rhodes, M.D., Wichita

VICE SPEAKER: Kenneth L. Derrington, M.D., Shawnee Mission; Edwin D. Rathbun, M.D., Liberal

AMA DELEGATE: Lew W. Purinton, M.D., Wichita

AMA ALTERNATE: F. Calvin Bigler, M.D., Garden City

AMA DELEGATE: Jimmie A. Gleason, M.D., Topeka

AMA ALTERNATE: Stephen F. Miller, M.D., Parsons

AMA DELEGATE: Linda D. Warren, M.D., Hanover

AMA ALTERNATE: Jay S. Schukman, M.D., Great Bend; Stuart C. Averill, M.D., Topeka

AMA DELEGATE: Warren E. Meyer, M.D., Wichita

AMA ALTERNATE: John P. Brockhouse, M.D., Emporia; Wayne O. Wallace, Jr., M.D., Atchison

The KMS Nominating Committee encourages additional nominations, which may be presented by delegates at the annual meeting.



AMA Initiative on Adolescent Health

The following is a summary of the AMA Board of Trustees Report RR, which was adopted at the AMA House of Delegates meeting in December. It is the background document on which the AMA will launch the initiative on adolescent health in 1987.

THE TRANSITIONAL period of adolescence is now recognized as a distinctive and stressful stage of human development. A young person's vestigial need for reliance on parents conflicts with the increased desire for self-assertiveness and independence. The linkage of this stress to risky and self-destructive behavior — such as alcohol and drug abuse, smoking, and unprotected sexual activity — has only recently been recognized by clinical and social scientists.

This new knowledge has not yet had an impact on adolescent health, and adolescents remain the only U.S. population group for whom morbidity and mortality rates are not significantly lower today than they were 20 years ago.

The following are among the contributory factors:

- Substance abuse among adolescents increased explosively in the 1960s and 1970s. While there has since been some leveling off, alcohol, tobacco, and drug use remain prevalent in this population group. Such use interferes with the developmental processes of adolescence, and can have long-term physical, psychological, and sociological consequences.
- Although statistics are incomplete, sexual activity is common among adolescents, and is often associated with risk-taking without consideration for potential consequences.
- Fifteen per cent of American adolescents require some form of intervention for emotional disturbances. More than one-third of adolescents' visits to physicians involve somatic complaints.
- Despite a perception of adolescence as a healthy time of life, morbidity and mortality rates for persons 15-24 years have risen 11% during the past 20 years.
- Violence has become an increasingly pervasive element in modern society.
- Each year, more than 1 million children and youths suffer serious abuse at the hands of their parents, guardians and others, which results in 2,000 to 5,000 deaths annually. Many more suffer from neglect — *i.e.*, lack of appropriate food, shelter,

clothing, medical care, supervision, affection, and intellectual and social stimulation.

Although these conditions are found across the cultural spectrum, the most profound and pervasive exacerbating factor is poverty, which puts children at greater developmental risk through the direct physical consequences of deprivation, the indirect consequences of severe stress on the parent-child relationship, and the overhanging pall of a depreciated status in the social environment. The problem is further compounded by the major shift in resources from the younger toward the older end of the population; 40% of all poor people in the nation are under age 18 years.

However, adequate income and high social status do not guarantee healthy growth and development; alcohol and drug abuse, suicides, and other social and physical problems are common among the privileged.

The AMA has a long-standing commitment to the improvement of the health and well-being of children and youth. Its educational, legislative, and regulatory initiatives testify to its commitment to the health needs of the young.

Building on this tradition, the AMA now finds that more direct interventions are possible and desirable. While adolescence, as a period of growth and change, entails a significant level of vulnerability, it also is a time of plasticity and responsiveness to environmental challenge. Thus it presents an exceptional opportunity for remediation and prevention of casualties — *i.e.*, interventions with the potential for lifelong impact.

Philosophy of an AMA Initiative

The picture isn't all bleak. Application of developing techniques and responsive innovations have produced measurable improvements in targeted behaviors. What is missing is a comprehensive and coordinated program to focus on the overall health of *all* adolescents and thereby address the underlying problems for which self-destructive behaviors are but the overt symptoms. Such a program would knit together successful programs that target specific high-risk behaviors in order to identify, quantify, prevent or remediate the broad spectrum of threats to the physical, intellectual, emotional, and social health and well-being of the nation's youth.

(Continued on page 76)

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*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

The one you know best keeps looking better

Please see next page for brief summary of prescribing information.

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® LA brand of propranolol hydrochloride (Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. Inderal is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of Inderal has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. Inderal has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, Inderal also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. **Hypertension:** Inderal LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. **CARDIAC FAILURE:** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior

to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. **General:** Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSEAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal tablets to Inderal LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg for mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg Inderal LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

REFERENCES:

1. Inderal LA National Compliance Evaluation Program. Data on file, Ayerst Laboratories.
2. Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985; 145: 1321-1323.

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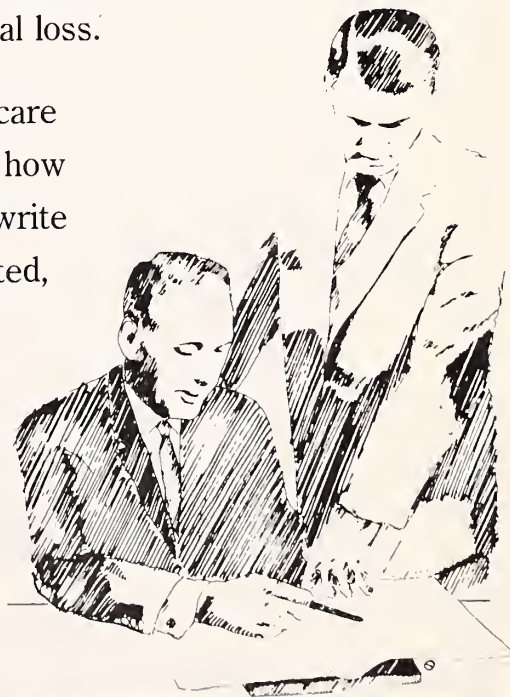
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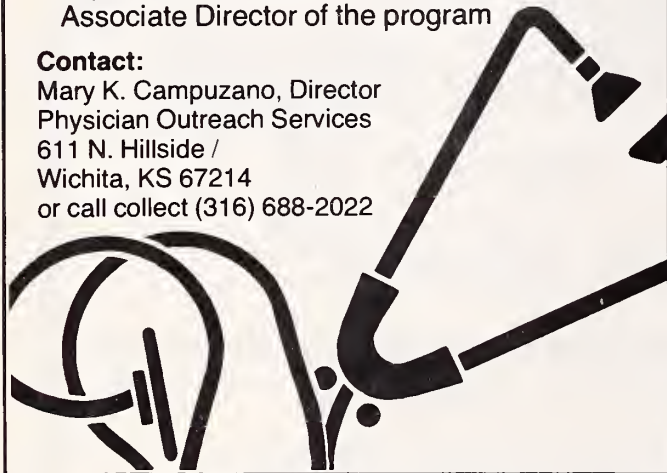
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Adolescent Health

(Continued from page 72)

Purpose

The broad purpose of the AMA initiative is to improve the health of adolescents. The effort will initially target four areas in which improvement would yield the greatest benefits to health:

- Prevention of substance abuse;
- Prevention of teen pregnancy and improved maternal and child care for those adolescents who do become pregnant;
- Reductions in attrition resulting from suicide,

traumatic injury, and other forms of violence, including family violence; and

- Provision of specialized health care services to the most vulnerable subgroups of teens.

A comprehensive approach will involve actions directed toward prevention of, and early intervention for, each of these risks to health, coupled with a strong emphasis on personal responsibility for achieving and maintaining good health, and on practical skills in accessing needed health care services. Such an approach will provide adolescents and their families with the knowledge, skills, incentives, and supports to make positive decisions in favor of healthy behaviors.

Developmental Plan

The major challenge is to integrate knowledge with experience, and this will require a sustained commitment. The AMA is committed to initiating the following action:

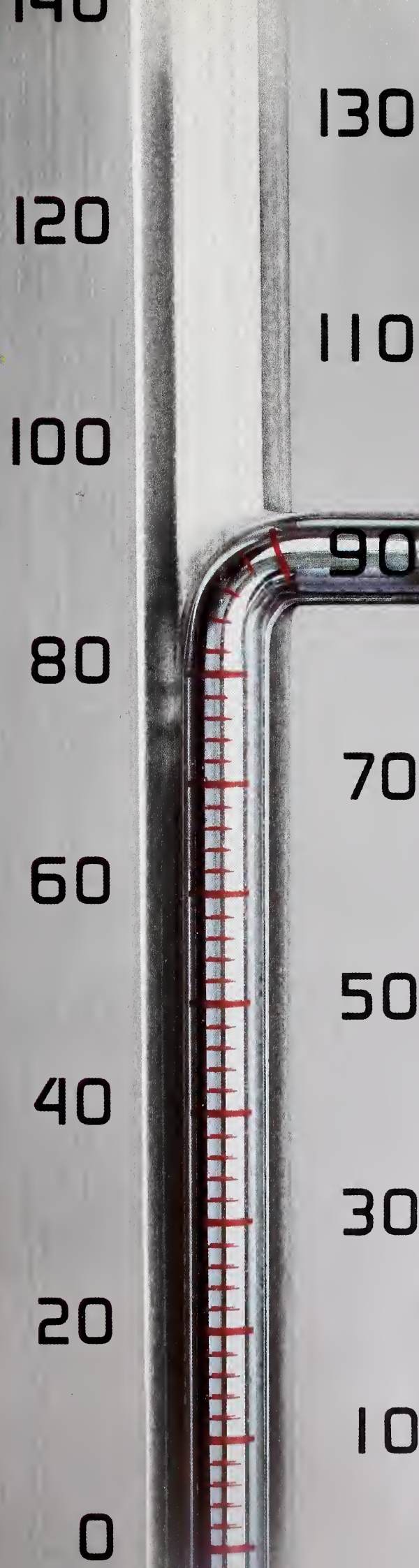
- Construction of coalitions;
- Establishment of a clearing house;
- Creation of a research agenda;
- Identification of effective programs; and
- Enhancement of physician knowledge.

Conclusions

The health of 40 million adolescents is a major challenge to American physicians as well as to society in general. The AMA is in a uniquely favorable position to accept that challenge. While the AMA and various other organizations have mounted significant programs to address specific problem behaviors, there is a need for a truly comprehensive and coordinated approach. Such an approach would provide a broad organizational base upon which all interested parties — in the health field, in education and social service, and in the community — could come together in common service to meet the health needs of the critically important adolescent population.



*Be an effective advocate for the medical profession.
Read the KMS NEWSLETTER, page 84a, to keep
abreast of critical issues.*



In mild to moderate hypertension

**THE FIRST
ONCE DAILY**

**CALCIUM
CHANNEL
BLOCKER**

NEW
ONCE DAILY



ISOPTIN[®] SR^{*}

(verapamil HCl/Knoll)

240 mg scored, sustained-release tablets



JAMES B.
38, black male, heavy smoker. Prescribed a diuretic by another physician last year for hypertension.

YOUR CONCERNS
Presents with "smoker's cough." Workup reveals a BP of 150/107.

A LOGICAL CHOICE FOR CONTROL OF HIS BP

ISOPTIN[®] (verapamil HCl/Knoll) because...

- Black hypertensives often have low plasma renin activity and generally do not respond favorably to beta blockers.
- Beta blockers may increase the likelihood of bronchospasm.

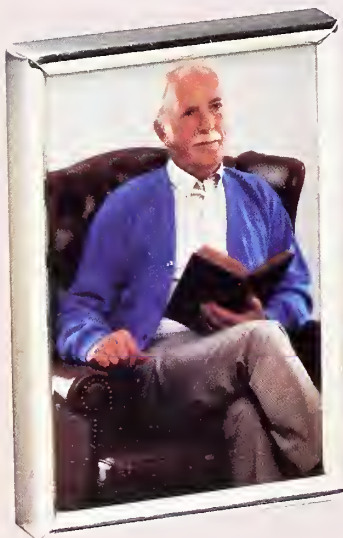
ALICE W.
65, diabetic, overweight. Her BP has elevated to 190/98.

YOUR CONCERNS
She's on daily insulin.

A LOGICAL CHOICE FOR CONTROL OF HER BP

ISOPTIN[®] (verapamil HCl/Knoll) because...

- Unlike most beta blockers and diuretics, ISOPTIN has no adverse effects on serum glucose levels.
- Unlike most beta blockers, ISOPTIN does not mask the symptoms of hypoglycemia.



THOMAS G.
70, asthmatic. In the past, BP adequately controlled with 25 mg hydrochlorothiazide daily.

YOUR CONCERNS
Today patient presents with symptoms of gout. Workup reveals high uric acid level, low serum potassium, and BP elevated to 180/98.

A LOGICAL CHOICE FOR CONTROL OF HIS BP

ISOPTIN[®] (verapamil HCl/Knoll) because...

- Unlike diuretics, ISOPTIN will not decrease serum potassium levels or elevate uric acid levels.
- Unlike beta blockers, ISOPTIN can be used safely in asthma and COPD patients.

JOHN K.
42, Annual physical uncovered diastolic BP of 102... confirmed on three successive office visits. Unresponsive to nonpharmacologic intervention.

YOUR CONCERNS
Salesman, spends many hours of his working day in car... total cholesterol level 300, HDL 35.

A LOGICAL CHOICE FOR CONTROL OF HIS BP

ISOPTIN[®] (verapamil HCl/Knoll) because...

- Unlike diuretics, ISOPTIN does not cause urinary urgency.
- Unlike either beta blockers or diuretics, ISOPTIN will not adversely affect his already seriously compromised lipid profile.
- Unlike with propranolol, fatigue and impotence are rarely reported.



**Antihypertensive therapy you
and your patients can live with**

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In mild to moderate hypertension
THE FIRST ONCE DAILY
CALCIUM CHANNEL BLOCKER

Brief Summary

ISOPTIN® SR
(verapamil HCl/Knoll)
240 mg scored, sustained-release tablets

CONTRAINDICATIONS: 1) Severe left ventricular dysfunction (see WARNINGS), 2) Hypotension (less than 90 mmHg systolic pressure) or cardiogenic shock, 3) Sick sinus syndrome or 2nd or 3rd degree AV block (except in patients with a functioning artificial ventricular pacemaker).

WARNINGS: **Heart Failure:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (see DRUG INTERACTIONS). Patients with milder ventricular dysfunction should, if possible, be controlled before verapamil treatment. **Hypotension:** ISOPTIN (verapamil HCl) may produce occasional symptomatic hypotension. **Elevated Liver Enzymes:** Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Periodic monitoring of liver function in patients receiving verapamil is therefore prudent. **Accessory Bypass Tract (Wolff-Parkinson-White):** Patients with paroxysmal and/or chronic atrial flutter or atrial fibrillation and a coexisting accessory AV pathway have developed increased antegrade conduction across the accessory pathway producing a very rapid ventricular response or ventricular fibrillation after receiving intravenous verapamil. While this has not been reported with oral verapamil, it should be considered a potential risk. Treatment is usually D.C.-cardioversion. **Atrioventricular Block:** The effect of verapamil on AV conduction and the SA node may cause asymptomatic 1st degree AV block and transient bradycardia. Higher degrees of AV block, while infrequent (0.8%), may require a reduction in dosage or, in rare instances, discontinuation of verapamil HCl. Patients with Hypertrophic Cardiomyopathy (IHSS): Although verapamil has been used in the therapy of patients with IHSS, severe cardiovascular decompensation and death have been noted in this patient population.

PRECAUTIONS: **Impaired Hepatic or Renal Function:** Verapamil is highly metabolized by the liver with about 70% of an administered dose excreted in the urine. In patients with impaired hepatic or renal function verapamil should be administered cautiously and the patients monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacological effects (see OVERDOSAGE).

Drug Interactions: **Beta Blockers:** Concomitant use of ISOPTIN and oral beta-adrenergic blocking agents may be beneficial in certain patients with chronic stable angina or hypertension, but available information is not sufficient to predict with confidence the effects of concurrent treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities. **Digitalis:** Clinical use of verapamil in digitalized patients has shown the combination to be well tolerated if digoxin doses are properly adjusted. However, chronic verapamil treatment increases serum digoxin levels by 50 to 75% during the first week of therapy and this can result in digitalis toxicity. Upon discontinuation of ISOPTIN (verapamil HCl), the patient should be reassessed to avoid underdigitalization. **Antihypertensive Agents:** Verapamil administered concomitantly with oral antihypertensive agents (e.g., vasodilators, angiotensin-converting enzyme inhibitors, diuretics, beta blockers, prazosin) will usually have an additive effect on lowering blood pressure. Patients receiving these combinations should be appropriately monitored. **Disopyramide:** Disopyramide should not be administered within 48 hours before or 24 hours after verapamil administration. **Quinidine:** In patients with hypertrophic cardiomyopathy (IHSS), concomitant use of verapamil and quinidine resulted in significant hypotension. There has been a report of increased quinidine levels during verapamil therapy. **Nitrates:** The pharmacologic profile of verapamil and nitrates as well as clinical experience suggest beneficial interactions. **Cimetidine:** Two clinical trials have shown a lack of significant verapamil interaction with cimetidine. A third study showed cimetidine reduced verapamil clearance and increased elimination to 1/2. **Anesthetic Agents:** Verapamil may potentiate the activity of neuromuscular blocking agents and inhalation anesthetics. **Carbamazepine:** Verapamil may increase carbamazepine concentrations during combined therapy. **Rifampin:** Therapy with rifampin may markedly reduce oral verapamil bioavailability. **Lithium:** Verapamil may lower lithium levels in patient on chronic oral lithium therapy. **Carcinogenesis, Mutagenesis, Impairment of Fertility:** There was no evidence of a carcinogenic potential of verapamil administered to rats for two years. Verapamil was not mutagenic in the Ames test. Studies in female rats did not show impaired fertility. Effects on male fertility have not been determined. **Pregnancy (Category C):** There are no adequate and well-controlled studies in pregnant women. ISOPTIN crosses the placental barrier and can be detected in umbilical vein blood at delivery. This drug should be used during pregnancy, labor, and delivery, only if clearly needed. **Nursing Mothers:** ISOPTIN is excreted in human milk, therefore, nursing should be discontinued while verapamil is administered. **Pediatric Use:** Safety and efficacy of ISOPTIN in children below the age of 18 years have not been established.

ADVERSE REACTIONS: Constipation 8.4%, dizziness 3.5%, nausea 2.7%, hypotension 2.5%, edema 2.1%, headache 1.9%, CHF/pulmonary edema 1.8%, fatigue 1.7%, bradycardia 1.4%, 3° AV block 0.8%, flushing 0.1%, elevated liver enzymes (see WARNINGS). The following reactions, reported in less than 1.0% of patients, occurred under conditions (open trials, marketing experience) where a causal relationship is uncertain; they are mentioned to alert the physician to a possible relationship: angina pectoris, arthralgia and rash, AV block, blurred vision, cerebrovascular accident, chest pain, claudication, confusion, diarrhea, dry mouth, dyspnea, ecchymosis or bruising, equilibrium disorders, exanthema, gastrointestinal distress, gingival hyperplasia, gynecomastia, hair loss, hyperkeratosis, impotence, increased urination, insomnia, macules, muscle cramps, myocardial infarction, palpitations, paresthesia, psychotic symptoms, purpura (vasculitis), shakiness, somnolence, spotty menstruation, sweating, syncope, urticaria. **Treatment of Acute Cardiovascular Adverse Reactions:** Whenever severe hypotension or complete AV block occur following oral administration of verapamil, the appropriate emergency measures should be applied immediately, e.g., intravenously administered isoproterenol HCl, levaterenol bitartrate, atropine (all in the usual doses), or calcium gluconate (10% solution). If further support is necessary, inotropic agents (dopamine or dobutamine) may be administered. Actual treatment and dosage should depend on the severity and the clinical situation and the judgment and experience of the treating physician.

OVERDOSAGE: Treatment of overdosage should be supportive. Beta-adrenergic stimulation or parenteral administration of calcium solutions may increase calcium ion flux across the slow channel, and have been used effectively in treatment of deliberate overdosage with verapamil. Clinically significant hypotensive reactions or fixed high degree AV block should be treated with vasopressor agents or cardiac pacing, respectively. Asystole should be handled by the usual measures including cardiopulmonary resuscitation.

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SCIENTIFIC ARTICLES

Penicillin Allergy Update

J. M. AGGARWAL, M.D.,* and J. B. NEIBURGER, M.D.,† Kansas City, Kansas

PENICILLIN is one of the most commonly prescribed antibiotics, and in spite of the many available alternatives, it is still one of the most potent antimicrobials. Similarly, penicillin has considerable potential for life threatening reactions. This review is aimed at refreshing the knowledge of those who use this antibiotic.

Incidence

The incidence of penicillin allergy varies from one study to another. In a report by the World Health Organization, the overall incidence of allergic reactions ranges from 0.7-10%.¹ Late reactions are least common. Still, penicillin allergy causes 75% of the anaphylactic deaths in the United States.² Reactions are more common in adults ages 20-49 years, although individuals at extremes of age are susceptible as well.

Reaction rates depend on the route of administration, most frequent with the intramuscular route and least frequent with the oral route.³ Intramuscular administration results in a very high tissue concentration locally and provides a high epitope density which increases the likelihood of reactions. Herman *et al* found twice the incidence of reactions with parenterally administered penicillin, ampicillin, and cephalosporin when compared to oral administration. Ahlstedt found only six recorded cases of anaphylaxis after oral administration of penicillin.⁴ There is equivocal evidence regarding the role of atopy, in general, on the individual's allergic response to penicillin. In contrast to the earlier reports which favored the role of atopy in the individual's immune response to penicillin,⁵ a later multicenter study sponsored by the American Academy of Allergy and Immunology found no significant cor-

relation between atopy and penicillin hypersensitivity,⁶ nor is there an HLA or racial predisposition to its development.

Intermittent administration of penicillin appears more likely to cause sensitization as compared to continuous high dose administration.⁷

The Antigen

Penicillin, by virtue of its low molecular weight (333d), cannot itself act as an immunogen. It is, however, a highly reactive substance and readily joins the serum proteins and polypeptides to form the immunogens that elicit the antibody response. Potential reaction sites on the molecule are shown in *Figure 1*. The main chemical nucleus of penicillin is 6-aminopenicilloic acid which consists of a beta lactam ring and a thiazolidine ring (*Figure 1*). As the ring structures open, the products formed are highly reactive and readily combine with the serum proteins, giving rise to potentially immunogenic antigens. Two immunogenic groups have been identified — the major and minor determinant mixtures.

*Major determinant*⁸: The term *major* refers to the relative amount of these antigens present. The pen-

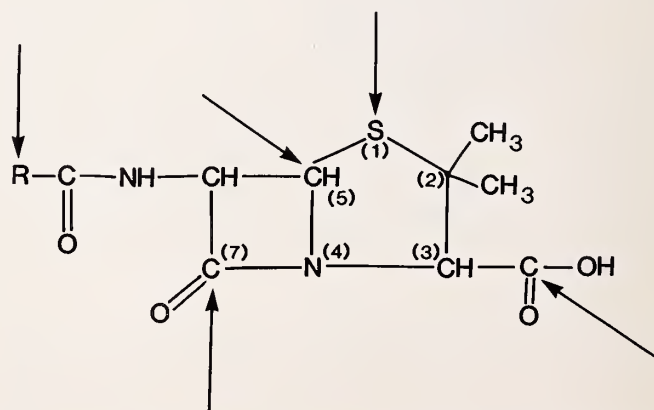


Figure 1. The main chemical nucleus of penicillin showing potential reaction sites on the molecule.

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icilloyl group is formed in the largest amounts and is referred to as the major determinant. It may be formed by penicillin itself reacting with the serum protein or via formation of a highly reactive penicillinic acid. The reaction is favored at the alkaline or neutral pH.⁹⁻¹¹ Penicillinic acid is formed in minute amounts during the manufacture of penicillin and, probably, also during storage of penicillin, particularly in solution. When administered, it readily forms the penicilloyl group. There is some controversy whether any penicilloyl group is formed during manufacture or storage.¹³ Ahlstedt showed that patients who received stored penicillin showed significantly higher antibody titers as compared to patients who received freshly prepared penicillin.

Minor determinant: These determinants are formed only in very small quantities (<5%). The chemical structures of the degradation products which act as haptens have not been defined as they are unstable and therefore difficult to recover. In the National Institute of Allergy and Infectious Disease collaborative clinical trial, the minor determinant mixture used contained benzylpenicillin, benzylpenicilloate, and benzylpenicilloyl-n-propylamine. The mixture was considered to be highly specific and reliable.¹²

Immune Response

All five classes of antibodies may develop against penicillin, and in virtually every individual — whether or not s/he has received penicillin — the antibodies may be demonstrated. The most likely sources of exposure are foods or pharmaceutical products.^{14, 15} Of all antibody classes, only IgE antibodies are of major clinical significance. The major determinant causes both IgE and IgG responses. The IgG plays a protective role; therefore, the reactions mediated via major determinant usually are not life threatening and consist mainly of cutaneous reactions. The minor determinant causes an IgE response only because larger amounts of antigen are required to cause the IgG response.¹⁶ Reactions such as anaphylaxis caused by minor determinant may be life threatening.

Clinical Manifestations

Immunologically mediated allergic manifestations can be classified in three groups:

Immediate: Manifested by pruritus, urticaria, angioedema, hypotension, laryngeal edema, and occasionally death. The feeling of impending doom or a sensation of a “lump” in the throat may be the first sign. These occur within one hour and are

associated with the reaction of the minor penicillin determinant with the mast cell bound IgE.

Accelerated: Manifested by delayed urticaria and angioedema, and are the result of circulating immune complexes and complement activation. This occurs within 1-72 hours.

Delayed: Serum sickness and erythematous rash appears after 72 hours, apparently the result of activation of sensitized T lymphocytes and cytotoxicity.¹⁷

Immunologically mediated, non-allergic manifestations include:

Hematologic: The development of a direct positive Coomb's test is a common occurrence in patients who receive high doses of IV penicillin. Few of these patients develop hemolytic anemia.¹⁸⁻²⁰ This is an IgG mediated reaction in which IgG reacts with the red cell bound penicillin antigen. The Fc portion of the IgG molecule binds to the Fc receptor of the macrophages which are removed by the reticulo-endothelial system and hemolyzed extracellularly.

Other hematologic manifestations are neutropenia, leukopenia, and thrombocytopenia mediated via the same mechanism. There has been a case report of inhibition of factor VIII activity attributed to anti-penicillin activity.²¹

Renal: Manifestations include the nephropathy of serum sickness, glomerulonephritis, and acute interstitial nephritis. Both humoral and cell-mediated immune mechanisms have been identified. Findings suggestive of humoral mechanisms include detection of methicillin penicilloyl group and immunoglobulin, and C₃ bound to the tubular basement membrane. Cell mediated immunity has been demonstrated by mononuclear infiltrates on renal biopsy.²²⁻²⁴

Maculopapular skin rash: These rashes are more common with ampicillin but can be seen as well with penicillin. This response is not IgE mediated as in urticaria. Elevated IgM penicilloyl antibody titers and IgM penicilloyl immune complexes have been suggested as causes of these rashes.²⁵ IgG directed against penicilloyl-intercellular epithelial structure complexes has been suggested as another mechanism of this rash.²⁶ A higher incidence of ampicillin rash is seen in patients with infectious mononucleosis, cytomegalovirus infection, chronic lymphocytic leukemia, and hyperuricemia.

Non-immunologically mediated reactions include²⁷⁻²⁸:

Jarisch-Herxheimer reaction: This syndrome classically develops 2-12 hours after starting anti-

biotics for spirochetal infections. The symptoms consist of chills, rigor, flushing, and arthralgias. The reaction is thought to be due to the liberation of toxic substances from the killed spirochetes.

Hoigne syndrome: Seen after the use of procaine penicillin or other depot preparations, the syndrome consists of severe disorientation which occurs within minutes of the penicillin injection. The patient experiences auditory and visual hallucinations, often accompanied by overwhelming anxiety and fear of death. Sometimes the patient has a sensation of respiratory distress and may have tachycardia. Features such as hypotension, edema of the face and mucous membranes, pruritus, skin rash and loss of consciousness, typically seen in penicillin allergy, are not seen in Hoigne syndrome. Another clue to the diagnosis is its occurrence only after the use of depot preparations with no reaction following exposure to crystalline penicillin preparations. Some investigators believe that microaggregates of penicillin enter the circulation and cause micro-pulmonary emboli. Another potential etiology is the effect of procaine which itself can lead to excessive cortical stimulation to the point of convulsions. There may be associated tachycardia, anxiety, and hallucinations. This second explanation is more widely accepted.

Diagnosis

The positive history of adverse reactions is useful in suspecting penicillin allergy, but the absence of history does not mean that there is no potential for reaction. Patients with past history of reactions are six times more likely to experience a reaction on subsequent administration as compared to patients with no history of adverse reactions to penicillin.²⁹ In addition to skin testing, various in-vitro tests have been employed.³⁰⁻⁴⁴

Skin tests: Skin testing is by far the most useful diagnostic procedure in the evaluation of patients with penicillin allergy. It has been found that patients with accelerated or late urticarial eruptions manifest skin test reactivity to major determinants of penicillin only, and almost all with a history of immediate reactions show positive skin tests to minor determinant.^{45, 46} It is important to properly perform skin tests for minor determinant, particularly when the history suggests immediate hypersensitivity. Until 1981, three deaths from skin testing were recorded in the literature.^{47, 48} Skin testing should not be taken lightly and should not be performed merely to satisfy curiosity. Skin testing is best per-

formed by experienced personnel. It may be considered for those patients who cannot be treated effectively with other antibiotics.

Major determinant is available commercially as Pre-pen, and is prepared by conjugating penicilloyl with polylysine as described by Parker.⁴⁹ Minor determinant is not yet commercially available, and different centers use a variety of protocols to test for sensitivity to minor determinant. In the NIH collaborative study, a minor determinant mixture consisting of potassium penicillin, benzylpenicilloate, and benzylpenicilloyl-n-propylamine was used. In this study, only 7% of the history-positive and skin test-negative subjects had reactions, while none of history negative, skin test negative subjects had any reaction on subsequent administration of penicillin. In the past, minor determinant has been either freshly prepared by alkaline hydrolysis of penicillin followed by neutralization and kept in solution, or has been frozen until needed. Some centers prepare the minor determinant by allowing the penicillin to remain at room temperature for several days, the so-called "old penicillin." None of these methods is well standardized, and the constituents of the mixture have been uncertain.

The prevalence of positive skin test reactivity changes with increasing time after the last known exposure to beta lactam drugs. In a study by Sullivan *et al*, 73% of patients were positive by skin testing within one year of reaction, 57% after one to ten years, and only 22% after ten years or more in the same population.⁵⁰ There is a fair degree of cross reactivity among various beta lactam antibiotics. If a patient reacts adversely to penicillin, s/he is very likely to be sensitive to other antibiotics containing the beta lactam ring.

RAST Testing: Significantly reliable RAST assays have been developed for the detection of antibodies against major determinants and are available commercially (Phadebas RAST penicillin G and V) but no reliable RAST assays are available for the detection of antibodies to the minor determinant.

In a study by Jarish *et al*, the overall correlation between skin tests with penicillin G and PPL (penicilloyl polylysine, major determinant) and RAST for penicillin G and V was 87%.⁵¹ In this study, no attempt was made to perform skin tests or RAST assay for minor determinants.

In a study by Kraft *et al*, attempts were made to develop minor determinant conjugates on the discs and perform RAST assays, but in this study, patients

(Continued on page 94)

Epilepsy and Driving Privileges

DAVID J. WALSH, M.D.,* *Kansas City, Kansas*

A DRIVER'S LICENSE, by state law, is a privilege to be regulated in the public interest. This fact is not well accepted as current styles of living and working, the present state of public transportation, and ingrained beliefs of teenage and adult society support the attitude that a driver's license is a necessity and a right. Thalwitzer¹ probably described the first traffic accident caused by epilepsy in 1906, and since then, the position of medical recommendation and licensing law has evolved from absolute prohibition to relative contraindication for the epileptic patient who seeks a driver's license. At present, the State of Kansas may issue a driver's license to a person who has had seizures — all other requirements having been satisfied — when medical evaluation deems the risk acceptable.

Current Kansas policy requires a one-year period free of seizures in the waking state immediately prior to licensing. Applicants with a history of seizure are required to say so on the license application. The Driver Review Section, thus notified, mails the applicant a form to be completed and returned by his/her physician. The form calls for diagnosis, type of seizure, seizure history, current medications, and current level of impairment plus the physician's recommendations. Each application is reviewed within 30 days by a medical panel composed of physicians appointed by, and serving at the pleasure of, the Secretary of Revenue. The panel, with no knowledge of the applicant's identity, evaluates each application by the medical facts provided. The panel's recommendation is given to the Director, Division of Vehicles, who makes the final decision. If a license is granted, an updated medical form must be submitted yearly until the driver has been seizure-free for five years. The law does not require a licensed driver who develops a new seizure disorder or recrudescence of a previously controlled one to report the change in status until his/her next license renewal. Physicians are not required to report driv-

ing age patients with seizures to the Driver Review Section but they are protected by law if they do so.

Neurologists are best qualified by training and experience to give an opinion in this matter but not all epileptic patients see neurologists. Many primary care physicians competently manage seizure disorders, and the knowledge gained about their patients' idiosyncracies, reliability, social circumstances, and response to treatment may exceed what a neurologist would learn during a single consultation arranged to complete a driver's license application. Those physicians who, by choice or necessity, find themselves assisting a patient with seizures to face the problem of driving should be prepared to discuss: the nature and likelihood of seizure-caused motor vehicle accidents, seizure control, seizure recurrences and the ways a patient can minimize them, effects of antiepileptic drugs on driving ability, and the chance of eventually driving without drugs.

Epilepsy is only one of the recognized medical impairments implicated in motor vehicle accidents; drivers with diabetes, cardiovascular disease, and mental illness also average up to twice the motor vehicle accident rate of the general population.² Loss of consciousness, expected as an epileptic manifestation, has been reported in 76% of a group of diabetic drivers, 62% of a group with cerebrovascular disease, and up to a third of alcoholic drivers.²

The danger the epileptic driver presents to himself and others is difficult to measure. Standard accident rates of 1.3 to 2 times that of the general driving population¹⁻³ are not valid for all epileptic driver subgroups. For example, epileptic men drivers have more accidents than non-epileptic drivers — men or women — but epileptic women drivers have fewer accidents than men drivers — epileptic or non-epileptic.⁴ Even with a relative risk twice that of the general population, epileptic drivers are responsible for no more than 0.3% of all driving accidents.⁵⁻⁷

Van der Lugt,⁵ who studied 155 seizure-caused motor vehicle accidents that occurred during a ten-year period, found 80% involved the epileptic driver's car only (generally leaving the road and striking an object) whereas 75% of the average accidents (defined by statistical data concerning accidents not

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involving epileptic drivers) involved the collision of two or more vehicles. Severe injuries were fewer (2.5%) and slight physical injuries more common (19%) than in the average traffic accidents (8% and 4%). Quoting evidence that alertness such as needed in city driving reduced seizure frequency, he reported 42% of the seizure-related accidents occurred outside "built up" areas compared to 18% of the average accidents. He thus concluded: "The accidents of persons with epilepsy were much less severe and much less apt to injure other persons than the average accident."

New drugs for the treatment of epilepsy and new information concerning the natural history of seizure disorders have improved prognosis. Delgado-Escueta, *et al*⁸ have estimated that 60-95% of all absence and grand mal seizures can be controlled with medication, while the rate for focal seizures or psychomotor seizures is closer to 50%. A history of neurologic insult,^{9, 10} presence of neurologic, social or psychiatric handicap,¹¹ family history of seizures,^{9, 11} or high seizure frequency before treatment^{10, 11} generally indicates a poorer prognosis for control. On the other hand, 244 patients (of all ages) followed after a first unprovoked seizure had cumulative recurrence risks of only 16% at 12 months and 27% at 36 months following the initial seizure.¹¹ In many cases then, the physician can use the type of seizure and the patient's overall medical condition to predict likelihood of control and therefore of eventual licensure.

Studies using the EEG to predict seizure recurrence have given conflicting results. In a study of 244 patients followed after a first unprovoked seizure, Hauser⁹ reported a generalized spike-wave, EEG pattern predicted a 50% recurrence compared to 14% in patients with normal EEGs or EEGs containing a different type of abnormal pattern. Others^{10, 11} have found no predictive value in EEGs performed at the time of the first seizure. Kuhl¹⁰ compared EEGs performed around the time of seizure onset with ones obtained after at least a year of treatment in 173 patients. In those cases where an initially normal EEG became abnormal, 83.4% of the patients had had seizures during the year prior to the second EEG. When an initially abnormal EEG became normal, only 32% of the patients had had a seizure. The EEG, then, may support a prognosis but it cannot substitute for clinical judgment.

Reassuring though these data are, they should not breed complacency. Not all the accidents are minor. A seizure-caused motor vehicle accident has killed another driver,¹² and Stanaway's¹³ discovery that

only eight of 21 active epileptic drivers had therapeutic anticonvulsant blood levels while 11 had never received professional advice about driving suggests there is room for improvement.

While awaiting the passage of a seizure-free year or driving with a controlled seizure disorder, patients have a marked interest in preventing further seizures. During this time, the physician may caution against factors thought to increase the likelihood of seizure such as alcohol abuse, excessive fatigue, or lack of sleep.¹³ Antiepileptic drug side effects such as dizziness or ataxia that might interfere with driving ability can be minimized by dose adjustment or a change of medicine. For most patients, sedation is unlikely with the usual doses of valproic acid and Dilantin. It's seen more frequently with phenobarbital and primidone and occurs somewhat less often with carbamazepine.¹⁴

Periodic visits to the physician during which seizure control, therapeutic anticonvulsant blood levels, freedom from drug side effects, and counseling are documented in the patient's medical record serve two useful purposes. First, the routine emphasizes the control a patient can and should take over his/her illness encouraging his participation and compliance. Second, a record that carefully documents seizure control can be useful in appealing an adverse decision from a licensing board.

Patients who otherwise have had excellent seizure control occasionally have breakthrough seizures under conditions of unusual fatigue or unaccustomed loss of sleep associated with work, school pressures, or social events. Anticonvulsant prescriptions run out or get lost and a seizure may result. A documented history of acceptable seizure control and the conditions under which it was achieved may serve as evidence that a breakthrough seizure was solely the result of an unfortunate lapse (in the usual regimen) and unlikely to recur once the patient's regimen is resumed. Occasionally, such an argument has prevented revocation of a patient's license.

The intense desire to have a license apparently causes some epileptic patients to falsify information. Maxwell and Legshorn⁷ reported that of 248 epileptic men, selected from an EEG Department's clientele and automatically ineligible for a driver's license by the laws then in effect, about half had a currently valid driver's license. Using the expected incidence of epilepsy in the general population, they estimated nine out of ten male epileptic drivers probably had lied on a driver's license application. Van der Lugt¹⁵ investigated subsequent driver's license applications by men disqualified from military serv-

ice because of seizures and found a similar fraction had not admitted epilepsy on the application. It seems likely, then, that the licensing process may not be the major force in determining which seizure patients are driving. It also seems likely that a patient might not report an occasional breakthrough seizure to his/her physician so as to keep his record clean.

If a patient continues to drive with uncontrolled seizures or fails to submit the necessary medical information to the Driver Control Bureau, the physician may find himself/herself on the horns of a dilemma. Physicians resist becoming part of a state's police system and want to protect the confidentiality of the patient-physician relationship,¹⁶ yet, this privilege is not absolute. Addressing this situation, LeBlanc¹⁷ argues that sometimes supervening public policy considerations mandate a breach of patient-physician confidentiality and justify the filing of an objective report. To support his position, he quotes the 1976 case of *Tarasoff vs Regents University of California* wherein the court stated:

We conclude that the public policy favoring protection of the confidential character of patient-(physician) communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins.

He finds further support in the *Principles of Medical Ethics* published by the American Medical Association in 1973:

A physician may not reveal confidences entrusted to him in the course of medical attendance or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

In Kansas, the law does not mandate disclosure but a physician who makes such a report, in good faith and to the proper authority, is protected from legal action. The decision then becomes one of clinical judgment and as LeBlanc puts it: "A physician must balance the intense desire of a patient to obtain valid motor vehicle licensure, on one hand, against countervailing public interest in traffic safety on the other."¹⁷

LeBlanc views the physician's responsibility to educate the epileptic patient about driving as part of the general obligation to inform patients of the inherent risks of any disease, condition or treatment, and feels that failure to do so can leave the physician vulnerable to a charge of negligence by the patient or an involved third party should an accident occur.

Landau,¹⁸ recognizing that arguments involving the safety of patients and others or the possibility of future license revocation often do poorly against the patient's desire to keep driving, recommends pointing out that insurance companies might deny retroactive accident coverage for a policy obtained with fraudulent medical information.

There seems little disagreement¹⁷⁻¹⁹ that while the patient may have the legal responsibility to inform the licensing bureau of his/her epilepsy, the physician should make careful notes of counseling sessions and recommendations in the patient's medical record. A formal letter outlining diagnosis and the patient's obligations¹⁹ or the patient's signature below the relevant entry in the chart have been recommended.¹⁷

Sooner or later the question of discontinuing antiepileptic drugs will come up. Neurologists generally consider tapering and discontinuing antiepileptic medicines after two to four years of control in cases of grand mal seizures, absence seizures, focal seizures, and psychomotor seizures.¹⁴ The prognosis for remission is good in these patients, but not universally so, and relapses occur. Some patients, fearing a relapse and unwilling or unable to risk loss of driving privileges for a year, will continue medication as long as they drive. For those patients who prefer to discontinue medication, the physician should review the likelihood of seizure recurrence, the risks to the driver and others should the seizures return, and the patient's obligations under the law. Patients who stop antiepileptic drugs may continue to drive unless they have a seizure.

Each of the states bordering Kansas (Missouri, Nebraska, Colorado and Oklahoma), permit epileptic patients to drive under certain conditions. None requires physicians to report drivers with seizures to the licensing authorities and all allow a physician to present extenuating circumstances in support of the driver's application for review by the state's medical board.

In Kansas, inquiries regarding the limitation of driving privileges for medical reasons may be addressed to: Mrs. Geraldine J. Urich, Driver Review Section, Division of Vehicles, State Office Building, Topeka, Kansas 66626-0001, 913-296-3601. Written requests for someone to appear before organizations and other professional meetings should be addressed to: Robert Bugg, Director of Vehicles, State Office Building, Topeka, Kansas 66626-0001, 913-296-3601.

(Continued on page 97)

Total Spinal Anesthesia — A Complication of Intercostal Nerve Block

DOUG FRIESEN, M.D.,* and R. H. ROBINSON, M.D.,† *Wichita*

POSTOPERATIVE incisional pain following thoracotomy can be alleviated by intraoperative intercostal nerve blocks using long-acting local anesthetics. These blocks can provide long acting analgesia to reduce postoperative pain medication requirements and may improve pulmonary function. Total spinal anesthesia is a rare complication, and when seen is usually accompanied by apnea and sudden marked hypotension.

Described here is a case of total spinal anesthesia following intercostal nerve block. This case is significant in that sudden hypotension did not occur immediately with the intercostal block. This early lack of hypotension may be a confusing sign in the differential diagnosis of total spinal anesthesia.

Case Report

A 60-year-old 117 kg white female was admitted to the hospital with a 20 x 16 mm mass in the right middle lobe of the lung. Past history included smoking 35 pack year, glaucoma, and hypertension. Her only current medication was Pilocaine. Her only known allergy was to penicillin. Physical examination revealed a morbidly obese white female with relatively normal clinical signs.

Hemoglobin was 15.7 gm/100 ml. Arterial blood gases on room air were: $p\text{CO}_2$, 40 mmHg; $p\text{O}_2$, 66 mmHg; pH, 7.38; and HCO_3 , 23.

The patient was premedicated with meperidine 40 mg, hydroxyzine 40 mg, and glycopyrrolate 0.2 mg IM one hour before surgery. After a left arterial catheter was placed, anesthesia was induced with sodium thiopental 250 mg and a paralyzing dose of pancuronium. Tracheal intubation was accomplished with a left-sided, double-lumen endotracheal tube. Anesthesia was maintained with 0.5-1.0% fluothane in a 50/50 mixture of nitrous oxide and oxygen. Muscle relaxation was monitored by a peripheral nerve stimulator. During one-lung anes-

thesia, N_2O was discontinued and fluothane concentration was maintained at 1.5%.

The anesthesia course was relatively uneventful during the initial 90 minutes of surgery. Blood pressure and pulse ranged from 140/90 to 110/80 torr and pulse averaged 90-110 beats per minute. Ventilation was controlled throughout and arterial blood gases were satisfactory.

At the completion of surgery and before the chest was closed, intercostal nerve blocks were performed at thoracic levels 4, 5, and 6 with a total of 18 ml of 0.75% bupivacaine without epinephrine. Following the blocks there was a slow fall in blood pressure from 120/80 to 82/42 during a 20-minute interval, and the pulse slowed from 118 to 90. A rapid volume of fluid (5% Ringers lactate), phenylephrine 0.1 mg, and calcium chloride 300 mg were administered; blood pressure and pulse improved. Fifteen minutes later the pressure fell again and had to be treated. During the next hour intermittent doses of phenylephrine were used to maintain systolic blood pressure above 100.

At the completion of surgery, reversal of muscle relaxant was accomplished with neostigmine 2.5 mg and atropine 1.0 mg; but the patient remained apneic despite evidence by nerve stimulation that full muscle strength had returned. Forty-five minutes after discontinuation of fluothane, neurologic examination revealed complete flaccidity of all muscle groups, absent deep tendon reflexes, and lack of any response to painful stimuli below the C5 dermatome level.

In the post-anesthetic recovery area, the patient remained hemodynamically stable. Approximately three hours after surgery the patient resumed breathing, became oriented, and moved all extremities. During the next two hours the patient regained full motion. The patient recovered uneventfully and was discharged on the 15th postoperative day.

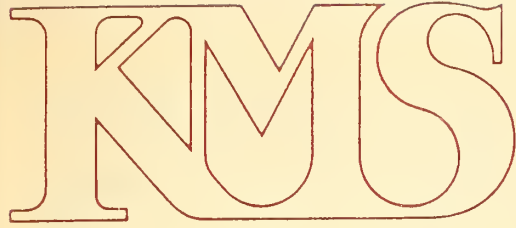
Discussion

Complications following intrathoracic intercostal nerve blocks have been well documented.¹⁻¹⁰ Central

(Continued on page 96)

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MARCH 1987

LEGISLATIVE UPDATE

As the 1987 Legislative Session reached its halfway point, quite a bit of action on health-related bills had taken place. Every KMS member will be receiving the regular Legislative Bulletin which contains a comprehensive listing of all legislation, but following are some of the highlights:

Optometric Scope of Practice. SB 113, the bill that expands optometrists' scope of practice has passed the Senate and is on its way to the House. It was substantially amended in committee to prohibit the treatment of glaucoma by optometrists, to authorize the removal of superficial foreign bodies only, and limit the use of steroids by optometrists to a fourteen day supply. KMS and the Kansas State Ophthalmological Society still oppose the bill, even though the amendments have tightened it up somewhat.

Tort Reform Issues. Two important pieces of legislation which affect physicians are very much alive and working their way through the process. HB 2471 broadens the repeal of the collateral source rule to all personal injury actions, not just medical malpractice; and HB 2472 broadens the \$250,000 limit on pain and suffering in the medical malpractice laws to include all personal injury actions, as well. Both bills came out of the House Judiciary Committee on an 11 to 10 vote, which followed party lines, with Republicans voting for and Democrats voting against. Both bills would apply to medical malpractice actions, and would enhance the tort reform laws KMS has achieved during the past couple of years.

Healing Arts Board Issues. Two bills that involve the Healing Arts Act are alive and moving through the process. SB 34 establishes a full-time executive director for the Healing Arts Board, in an attempt to consolidate the administrative responsibilities into one position (KMS supports the bill). The issue of physician assistant prescribing is being dealt with in Substitute for SB 35, and at KMS request, language has been amended into the bill that would require the Board of Healing Arts to write rules and regulations specifically regulating and limiting the prescribing by PAs in various practice settings. KMS will continue to work to assure that this area of delegation and supervision is tightened up appropriately.

Smoking in Public Places. HB 2412, introduced at KMS request, would regulate smoking in public places. The bill would require that no-smoking areas be designated in every public place and public meeting. The bill may have a difficult road toward passage.

In This Issue...

- Legislative update
- AG rules chiropractors not physicians
- Ending physician/patient relationship
- AMA unified membership
- Physicians can reduce violence
- Protect your assets
- KMS Annual Meeting
- AIDS task force
- Dr. Chaney elected
- Installment dues schedule
- Medical Assistants to meet 5-15-87
- Medicare:
 - Info available
 - Means testing
 - Public forums
- KMS dues a bargain!
- Free subscription

Abortions. Two bills relating to abortion are under active consideration. SB 86, which has passed the Senate, requires physicians who perform abortions in their office to file annual reports with the Department of Health for statistical purposes. The bill has been substantially amended to provide for strict confidentiality in all respects. Another bill, SB 225, would require parental consent before certain minors could receive an abortion. The bill is extremely controversial and at press time had not yet been passed out by the Senate Judiciary Committee.

If you have any questions about the above legislation, or any other bills, please contact the KMS office at 1-800-332-0156.

AG RULES ON CHIROPRACTIC ISSUE

Attorney General Bob Stephan ruled March 5 that chiropractors may not use the term "physician" in conjunction with their name. In a dispute that is almost three years old, the AG responded to a Board of Healing Arts request for an interpretation of current law. Chiropractors had contended that the law allowed them to use the terms "chiropractic physician." KMS disagreed, since the term "physician" historically has meant someone licensed to practice medicine and surgery. To settle the matter, the Healing Arts Board asked the Attorney General to research the law and the AG agreed with the KMS position on the issue.

ENDING A PHYSICIAN/ PATIENT RELATIONSHIP

With few exceptions, a patient may terminate the relationship at any time. The physician, however, must avoid any action that could be construed as abandonment. The basic rule is to give reasonable notice of intent to terminate. What is reasonable is determined by the circumstances such as the current medical needs of the patient.

There are established notification procedures--newspaper notices and letters to all patients--when a physician retires or moves. On an individual basis, great care should be taken to document the procedure to prevent future liability. This should include notification of a date of termination by certified mail (return receipt). This letter should state that the patient's records will be furnished to another physician at the patient's request. The letter and receipt should be filed with the patient's original records. Even when records are sent to another physician, send a copy--never the original record. Nothing in the letter or records should be stated in a way that would be a problem if read in court.

If a physician finds it necessary to terminate care of a hospitalized patient, s/he must be sure that another competent physician has assumed full responsibility. This move, too, must be carefully documented.

Whenever a physician is involved in termination or in accepting a patient terminated by another physician, it is essential that the roles of all involved be clear and documented.

Adherence to these guidelines will protect the physician from legal difficulty in most cases. However, if the patient involved is particularly troublesome or if the circumstances are unusual, an attorney should be consulted.

AMA UNIFIED MEMBERSHIP	After its implementation by the KMS House of Delegates in 1985, the subject of AMA unified membership continues to generate strong feelings among Kansas physicians. KMS continues to experience membership attrition as a result of the unified membership requirement. At the upcoming May meeting of the House of Delegates, this issue will be considered and debated again. At least one resolution has been submitted to repeal the unified membership requirement, which takes a 2/3 majority vote of the delegates present at the meeting. In February, the KMS Council authorized a survey of the membership to gauge the sentiment for continuing the unified membership requirement. The random survey will be sent to current members, as well as to those who dropped their membership following unification.
ALERT PHYSICIANS CAN REDUCE VIOLENCE	Violence--particularly against the elderly--can be reduced by physicians who take time to do thorough patient examinations and explore histories in detail. Physicians are familiar with risk factors and may spot potential victims and assailants before severe trauma or death occurs. In Kansas, such abuse must be reported to the local SRS office.
PROTECT YOUR ASSETS	A booklet, <u>Protecting Your Family Assets</u>, a guide book for physicians and other professionals, is available for \$4.50 from the Massachusetts Medical Society, Dept. of Education & Communications, 1440 Main St., Waltham MA 02254; 617-893-4610.
KMS ANNUAL MEETING	The KMS Annual Meeting will take place April 30-May 3 at the Holidome in Manhattan: Thursday, April 30--Sports Day; Friday, May 1--First House of Delegates & AMA-ERF Dinner; Saturday, May 2--Scientific Program, Installation of KMS President and President's reception; Sunday, May 3, Second House of Delegates and Council meeting. MARK YOUR CALENDAR!
AIDS TASK FORCE	<u>Lt. Gov. Jack Walker, M.D.</u>, acting director of the Kansas Department of Health & Environment, has announced that he will impanel a special task force to determine the state's "proper role in responding to the various health, social and educational problems posed by this serious disease." The selection of task force members is currently underway.
DR. CHANEY PRESIDENT OF FAMILY HEALTH FOUNDATION	<u>Ernie J. Chaney, M.D.</u>, Wichita, was recently elected President of the Family Health Foundation of America. Dr. Chaney is currently the Director of the Family Practice Residency Program at St. Joseph's Medical Center, Wichita, and is Associate Professor of Family & Community Medicine at the University of Kansas School of Medicine-Wichita. The Family Health Foundation (located in Kansas City) is the philanthropic arm of the American Academy of Family Physicians, of which Dr. Chaney is a past president. In his new position, he will also serve as Chairman of the Board of AAFP Insurance Services, Inc., a wholly owned subsidiary of the Foundation. He has served on the Foundation board since 1980.

INSTALLMENT DUES
PAYMENT SCHEDULE

The AMA portion of the installment payment plan is due in the KMS office no later than April 1. If you are paying through your county medical society, please pay in advance of April 1 so that the county will have time to forward your dues to the KMS by April 1.

KANSAS MEDICAL
ASSISTANTS SOCIETY

The Annual Meeting of KMAS will be held Friday, May 15, at the Salina Holiday Inn. Topics to be addressed include pre-certification for Cap Plus, Choice Care HMO, and other programs; pre-admission review performed by KPMC; and requirements of specific insurance carriers. Encourage your medical assistant(s) to attend so that s/he can do a better job of claims processing in your office. For registration information, contact Mary Jane Weddle, 913-357-6171.

MAY 15, 1987
SALINA

MEDICARE:
INFO AVAILABLE

A 7-minute VHS or Beta videotape is available from BC/BS. The tape briefly describes Medicare participation, timeliness of claims processing, and HCPCS coding changes. To obtain the tape on loan basis, either write to Dwight Wicker, Blue Cross-Blue Shield, Box 239, Topeka 66601, or call 1-800-432-3597 (Topeka: 295-4713).

MEDICARE:
MEANS TESTING

The time to establish "means testing" under Medicare may be near at hand. The consensus view by a Congressional panel of experts was that Medicare cannot survive in its present form. Means testing is one of the recommendations contained in AMA Board of Trustees Report MM, approved last June. Panelists before the Congressional subcommittee also emphasized the need to improve coordination of acute and long-term care.

MEDICARE:
PUBLIC FORUMS

A gratifying number of physicians participated in the open public forums conducted by Congressmen Glickman and Slattery last month in Topeka and Wichita. The main emphasis of testimony centered on the disparity of reimbursement with Kansas receiving lower rates of reimbursement than most states. The physicians also objected to the latest proposal of including RAPs (radiologists/anesthesiologists/pathologists) in the DRG system. The Kansas Medical Society also submitted a strongly worded written statement. The Congressmen seemed to be sympathetic to these concerns. Organized medicine is signing on congressional co-sponsors opposing RAPs legislation.

KMS DUES A BARGAIN!

A review of the membership dues for the 52 state medical societies (includes Puerto Rico and Washington DC) reveals that only three--Oklahoma, Delaware, and Nevada--have lower annual dues than Kansas' \$220. Pennsylvania has the highest (\$800), while Nevada is lowest (\$180). The nationwide average is \$322.

FREE SUBSCRIPTION

Alcoholism & Addiction Magazine will be sent free of charge to any U.S. licensed physician who requests it. It is hoped that this effort will enhance the understanding of the nation's number 1 medical problem. To take advantage of this offer, send your request on your professional letterhead to: Alcoholism & Addiction Magazine, 23860 Miles Road, Cleveland OH 44128 before April 30, 1987.

KEEP YOUR MEDICAL ORGANIZATION VITAL! DUES ARE DUE NOW!

CURRENT COMMENT

Evaluation of Clinical Immunologic Tests

NABIH I. ABDOU, M.D., Ph.D.*; RONSUKE SUENAGA, M.D.† and NANCY BECKER, M.D.‡,
Kansas City, Kansas

DEMANDS FOR laboratory tests in clinical immunology continue to grow. It is very important that clinicians understand the indications and limitations of these tests and be able to interpret them. This discussion will be limited to the more frequently used tests.

Protein & Immunoglobulin (Ig) Measurements

Quantitation. The assessment of IgG, IgM, and IgA in body fluids involves three laboratory techniques: electrophoresis, immunoelectrophoresis, and quantitation of major Ig classes by nephelometry, radial immunodiffusion, radioimmunoassay, or enzyme-linked immunoassay.

Quantitation of Ig is indicated in suspected primary or secondary humoral immunodeficiency states. Subsequent monitoring of serum Ig is helpful in following patients receiving gammaglobulin reconstitution therapy. Quantitation of serum Ig levels can assist in distinguishing benign from malignant monoclonal gammopathy. In the latter case the levels of normal Igs are usually decreased while they are typically unaltered in the benign form. Detection of elevated IgM levels in cord blood would be helpful in infants suspected of congenital infections and in the diagnosis of trypanosomiasis and tropical splenomegaly. There is no clinical indication for the measurement of IgD, unless IgD myeloma is suspected.

Measurement of Ig in urine is possible but has its problems. Ig molecules may be split making standardization difficult. The combination of pro-

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tein electrophoresis and immunoelectrophoresis is more reliable.

Quantitation of Ig in cerebrospinal fluid (CSF) should be performed on unconcentrated CSF since concentration procedures will lead to aggregation of Ig and a falsely low value. High CSF-IgG levels relative to total protein or albumin frequently accompany diseases such as multiple sclerosis and subacute sclerosing panencephalitis.

Electrophoresis & immunoelectrophoresis. Electrophoresis is used to screen for paraproteinemias and polyclonal gammopathy states. It provides important quantitative data for albumin and various globulins, but will not give any quantitative information regarding the various Ig classes.

Immunoelectrophoresis (IEP) is valuable in identification of monoclonal Ig, but it is not a quantitative technique and should not be used for systematic screening of serum proteins. IEP is indicated in diagnosis and characterization of monoclonal component in multiple myeloma, macroglobulinemia, heavy chain disease, amyloidosis, cryoglobulinemia, and Bence Jones proteinuria.

Measurement of total IgE. Clinical usefulness of determining serum IgE levels is limited. Preferred methods are enzyme linked immunoabsorbent assay (ELISA) or solid phase radioimmunoassay (RIA). Total IgE determinations are useful in the diagnosis of hyper IgE syndrome. IgE levels, however, are of limited value in differentiating IgE from non-IgE-mediated disorders. IgE levels can be in the normal range in IgE-mediated diseases and can be increased by non-atopic mechanisms such as para-

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TABLE I
CONDITIONS IN WHICH RAST TESTING WOULD
BE USEFUL IF IMMEDIATE SKIN TESTING
COULD NOT BE PERFORMED

- Dermatographism or severe dermatitis.
- Cases where drugs would influence results of skin testing and cannot be discontinued (*e.g.* antihistamine).
- High risk of anaphylaxis upon skin testing.
- Unsuitable antigens (*e.g.* toxic, water insoluble, or highly sensitizing substances).
- Food or drug allergies if antigens are known and well characterized.

sitic infestation. Following IgE levels is of limited value during immunotherapy of allergy states, but can be valuable during treatment of patients with allergic bronchopulmonary aspergillosis who have had previously elevated IgE.

Measurement of specific IgE. The radioallergo-sorbent test (RAST) or ELISA can detect specific IgE. While specific IgE testing is not essential in any clinical situation and does not replace obtaining a careful patient history and immediate hypersensitivity skin testing, it is useful in situations where skin testing would be contraindicated or unreliable (*Table I*).

Specific IgE measurements are not appropriate for hypersensitivity states in which IgE-mediated mechanisms are not involved (*e.g.* contact dermatitis).

Complement measurements. Several options exist to assess the complement system: functional measurement of the entire complement system (CH50); functional measurements of individual components; or immunochemical measurements of individual components with specific antisera. Sera or body fluids should be assayed for complement within one

hour after collection or kept frozen at minus 70C until tested to avoid decay or degradation of the various components. Complement levels measure the balance between synthesis and consumption. Acute inflammatory conditions, for example, will elevate complement levels by increasing synthesis. Increased consumption (*e.g.* immune complex disease) or decreased synthesis (*e.g.* genetic deficiency or hepatic failure) will lead to low complement levels.

Complement measurements are valuable in patients with recurrent Neisserial meningitis (congenital deficiency of terminal components), hereditary angioedema (C1 inhibitor deficiency), and immune complex diseases (*e.g.* lupus nephritis).

Detection of immune complexes. Several methods, none ideal, exist for the diagnosis of diseases due to immune complexes. Detection of circulating immune complexes is not essential in any clinical condition and their presence is not specific for any clinical state. Immune complex-induced lesions (*e.g.* glomerulonephritis) can exist without detectable circulating immune complexes. Conversely immune complexes are often present in serum when no evidence of typical immune complex-associated tissue deposition exists. However, the detection of immune complexes may be helpful to monitor disease activity in conditions such as rheumatoid arthritis or systemic lupus erythematosus associated with active vasculitis. Immune complex levels are also valuable in following the effects of plasma exchange in immune complex-mediated diseases.

Direct analysis of tissue samples (kidney, skin) for evidence of immune complex deposits is preferable when possible. Such analyses cannot be replaced by detection of circulating immune complexes.

TABLE II
ANTINUCLEAR ANTIBODIES

Pattern	Occurrence	Disease Association	Antigen
Homogeneous	Most common	Autoimmune disease Infections Malignancy	Nucleohistones
Peripheral Speckled	Rare Uncommon	SLE SLE MCTD (mixed connective tissue disease) Myositis Scleroderma	DNA ENA (extractable nuclear antigen)
Nucleolar	Rare	Scleroderma	RNA

TABLE III
MISCELLANEOUS AUTOANTIBODIES

<i>Autoantibody</i>	<i>Disease Associations</i>
Microsomal thyroid	Chronic thyroiditis
Thyroglobulin	Chronic thyroiditis
Mitochondrial	Primary biliary cirrhosis
Smooth muscle	Chronic active hepatitis
Anti-acetylcholine receptor	Myasthenia gravis
Anti-islet cell	Type I diabetes mellitus
Rheumatoid factor	Rheumatoid arthritis
Anti-adrenal cortex	Idiopathic adrenal insufficiency
Anti-intercellular substance of stratified squamous epithelium	Pemphigus
Anti-basement membrane of stratified squamous epithelium	Pemphigoid

Four methods are commonly used for the detection of immune complexes: Clq solid phase or fluid binding test; conglutinin assay; monoclonal rheumatoid factor inhibition; and Raji cell assay.

Detection of Autoantibodies

Antinuclear antibodies (Table II). Antinuclear antibodies (ANA) are present in almost all patients with systemic lupus erythematosus. Low titer ANA is present in several clinical states, including normals, and especially in the aged population. The ANA is most useful to exclude the diagnosis of lupus since the majority of active lupus cases have a positive ANA test.

Different auto-antibodies may produce different patterns of ANA. Homogeneous patterns are mainly directed against nucleohistones. It is the most common pattern detected and occurs in several autoimmune diseases, infections, and malignant states. A peripheral pattern is due to antibodies against DNA and is specific for systemic lupus erythematosus. The antibodies associated with speckled staining are usually directed against extractable nuclear antigens (ENA). The latter could be either ribonuclease resistant (Sm antigen), or sensitive (RNP antigen). Anti-Sm and anti-RNP antibodies are present predominantly in systemic lupus erythematosus and mixed connective tissue disease respectively. A nucleolar pattern is characteristically present in progressive systemic sclerosis.

Anti-DNA antibodies. Anti-single stranded DNA antibodies are present in several disease states and therefore not generally a helpful clinical test. Anti-double stranded DNA antibodies, however, are

characteristic of active systemic lupus erythematosus. These are assayed either by radioimmunoassay using radiolabeled DNA or by an immunofluorescent technique using the kinetoplast of the protozoan *crithidia lucilia* as the source of DNA.

Miscellaneous autoantibodies (Table III). Thyroid autoantibodies directed against microsomal antigen and thyroglobulin are present in the majority of patients with chronic thyroiditis. A positive test, however, does not eliminate the diagnosis of conditions such as thyroid adenocarcinoma or Graves disease. Mitochondrial antibodies are characteristic of, but not specific for primary biliary cirrhosis. Smooth muscle antibodies are frequently found in high titer in sera of patients with chronic active hepatitis. Anti-acetylcholine receptor antibody is characteristic of myasthenia gravis. Anti-islet cell antibody is present in some cases of insulin-dependent diabetes mellitus.

Rheumatoid factor is an antibody directed against the Fc portion of IgG. It can be detected by latex agglutination test and is present in several clinical conditions and in elderly normal persons. It has limited diagnostic value, although it is one of the criteria used to make a diagnosis of rheumatoid arthritis.

Several other autoantibodies have been described and are only minimally helpful in the diagnosis of certain diseases. None of these autoantibodies is specific — *e.g.* anti-adrenal cortex antibodies in idiopathic adrenal insufficiency; antibodies to intercellular substance of stratified squamous epithelium in pemphigus; antibodies to basement membrane of stratified epithelium in pemphigoid.

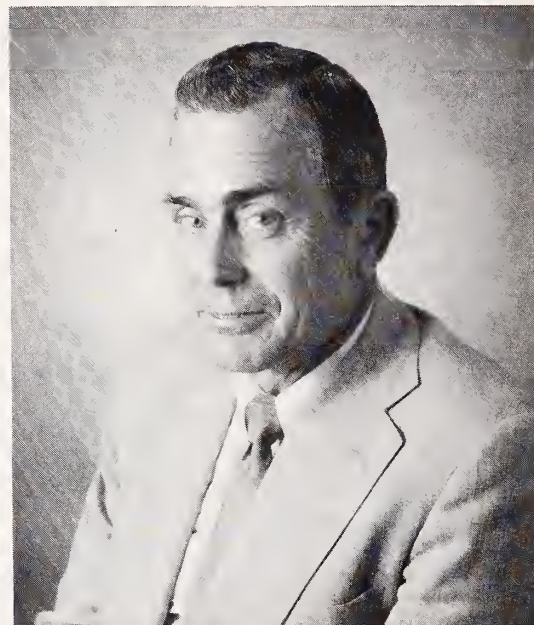
Lymphocyte Evaluations

T & B cell determination. Enumeration of T and B cells provides information for (1) the assessment and monitoring of primary immunodeficiencies; (2) the diagnosis of secondary immunodeficiency; (3) the classification of lymphoproliferative disorders; (4) the diagnosis of acquired immunodeficiency syndrome (AIDS); and (5) the monitoring of graft rejection in organ transplant recipients. It is of little or no clinical value in cases of infectious, autoimmune, or nonlymphoid malignant diseases.

T cell numbers and their subpopulations — helper (CD4), suppressor (CD8), and pre T (CD1) — can be determined by monoclonal antibodies using the indirect immunofluorescent technique and flow cytometry. B cell numbers can be determined by labelling the surface membrane Ig or B cell antigen

(Continued on page 92)

PRESIDENT'S MESSAGE



AN ISSUE which has been relatively quiet for several years has recently heated up considerably. The issue is whether or not physician assistants and advanced trained nurses should be able to write prescriptions. The flap started when the Attorney General recently ruled that nurses were not allowed to prescribe, but PAs working under a physician's supervision could prescribe drugs. The KMS position has long been that neither PAs nor nurse practitioners should be authorized to initiate prescription orders except in closely supervised and regulated settings. The KMS Council unanimously endorsed that position at its February 7 meeting in Salina.

This is a complex issue involving physician extenders with different levels of training, who function in a wide variety of practice settings. One area of concern which repeatedly comes up is the use of physician extenders in remote or satellite offices, where a supervising physician is not regularly present. Another troublesome area is the concept of "PA entrepreneurship" which is a new term to describe a "business" venture wherein one or more PAs hire a physician to supervise their activities. These are

examples of situations that raise concern about what constitutes appropriate supervision.

The bottom line for KMS is quality patient care. Our legislative efforts will be aimed at trying to allow the appropriate use of physician extenders, while assuring the public that continuous physician input and supervision over patient care is maintained at all times.

F. J. Bichelmeier MD

President



EDITORIAL COMMENT

Locum Tenens

AT THE MOMENT, one of the more intensely pursued medical and social issues is the dilemma of surrogate motherhood. To date, the heat exceeds the light, a condition that has become almost routine in these days when the much cited technology thrusts ethical problems on the profession and public before either is quite ready to handle the ramifications. Together, medicine and society have always been in a seeming imbalance. Medical capabilities have strained social restrictions while medical incapacities have increased society's demands for cure and solace.

The case at hand, perhaps judicially resolved by the time this is in print, involves on the one hand a straightforward business arrangement: a childless couple, (1) contracted with a woman of proved fecundity to bear a child; (2) produced by artificial insemination involving her own ovum and a sperm from the husband of that couple; (3) transfer of the child at birth to the couple for adoption. In this case, "surrogate" is not entirely accurate since it implies, as in animal breeding, the custodianship of a "foreign" embryo by an unrelated mother until presumed completion at birth. "Natural" has not caught the public fancy in this or similar cases although it is technically correct. Perhaps it is the media or simply that society rejects it in this instance, thinking the connotation inappropriate. On the other hand it seems suitable to us as a demonstration of the human emotional point: the lady changed her mind and, legal though the structure is, the testimony has reflected the deeply emotional factors on both sides.

It happens that the child, an obvious and natural concern for all sides, is not a voiceless focus. Separate legal counsel holding temporary custody has been appointed. Significantly, this source and three supporting psychologists have stated flatly that the natural mother should not have custody of the child.

The reproductive systems have produced a major share of the ethical perplexities confronting medicine and society. In this sense, however, this case has less direct bearing on medical ethics. The employment of a substitute mother is not a primarily medical factor. The sociolegal question of such arrangements is a thing apart: once established, the

pregnancy would presumably follow its physiologic course. Even so, the course of such judicial procedures produces a maze of minutiae that assures the medical activity will be under continuing scrutiny. From one side society continues its expectation of miracles and relief from threats to its health, encouraging research and technical development — and problems. From the other side, offended religious, moral, and ethical philosophies demand restraints, even abolition of professional capabilities and directions.

Thus, the mechanics of the legal process produce a penetration into medical matters that has an effect on the action of medicine through the perceptions of the public mind of improper directions and use of technology. The unorthodoxy is frightening to many and the presumed potential for a medical world with control over society obscures the fact that medicine is bringing more benefits than dangers.

An estimated 500 or more substitute mother cases have come to fruition with apparent satisfaction on both sides. Increasingly the medical role will come into the process as the physician must assess critically the emotional status of the patient and thus enter into the transaction, if only in a tangential manner. Obstetricians have always been certain that more emotional concerns have been allotted to them than to any other specialty (aside from psychiatry). Moreover, it should not be forgotten that there is a potential for some knotty problems of privacy rights, and certainly, the legal realm of contracts seems to be undergoing some remarkable changes these days. It enhances the chance that when the physician assumes such a position of authority the test of medical judgment will be after the fact.

Whatever the immediate outcome of the current case, we can be assured that appeals by the losing side will be initiated. The result recalls the comment of Secretary of State George Shultz in an early Congressional appearance in connection with the Iran crisis when he remarked to one of the numerous committees, "Nothing ever gets settled in Washington." One is justified in applying the thought to the philosophical crisis confronting medicine as well. — D.E.G.



Chiropractors and Staff Privileges

WAYNE T. STRATTON, J.D., *Topeka*

FROM TIME TO TIME, questions arise as to whether chiropractors are entitled to medical staff privileges. Attacks have been made periodically upon hospital refusal to grant such privileges, but courts have typically been unreceptive to such claims.

For example, an Oregon court ruled that a county hospital was not required to amend its bylaws to allow for an application for privileges submitted by a chiropractor. In an Ohio case, a chiropractor challenged a hospital's refusal to perform x-rays and a bylaw provision restricting staff privileges to medical doctors, osteopathic doctors, dentists, and podiatrists. In upholding the hospital's position in all respects, the court stated the following:

The record amply supports the conclusion that the appellant failed to demonstrate that access to the hospital's services was essential to the performance of services within his personal scope of authority, or whether any such necessity would be sufficient to justify the additional burden on the hospital.

In some states, action has been taken to change that result. For example, Florida has enacted legislation that permits chiropractors limited access to hospital x-ray and laboratory reports. At least one state has an administrative rule requiring radiologists to provide services to licensed chiropractors upon referral of patients. Kansas, however, has not enacted such a requirement. Indeed, the Kansas Supreme Court has stated that the Board of Directors



of a hospital has "plenary power to select its professional staff and the state has expressed a policy not to interfere with that selection."

Regulations defining licensure for hospitals, as promulgated by the Kansas Department of Health and Environment, require that a licensed hospital have an organized medical staff. A medical staff is defined as an organization of "physicians (and dentists where appropriate) who are appointed by the governing authority to attend patients within the hospital." In addition, the regulations state that any person admitted to a hospital "shall be under the care of a physician" and that all medical orders "shall be given by a physician or dentist" and "signed or countersigned (initialed) by the attending physician." Those regulations have generally been interpreted as prohibiting medical staff appointment for chiropractors. They do not prohibit hospitals from permitting access to hospital laboratory and x-ray services under conditions deemed appropriate by the hospital or granting allied clinical privileges under the same conditions as other categories of practitioners might obtain such limited privileges.

Note should also be made of the requirements of the Joint Commission on Accreditation of Hospitals

* KMS Legal Counsel

Editor's Note: This is the 17th in a series of regular columns concerning current subjects of legal interest to physicians. For the sake of brevity and clarity, citations and footnotes are omitted.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE or the Kansas Medical Society. For further information, contact Mr. Stratton, 215 E. 8th, Topeka, KS 66603; 1-800-332-0248.

and the Medicare conditions of participation, neither of which mandates medical staff privileges for chiropractors. The JCAH standard for the medical staff states that the staff shall include "fully licensed physicians" and that it "may include other licensed individuals permitted by law and by the hospital to provide patient care services independently in the hospital." JCAH states that an individual who is permitted to provide patient care services on an independent basis is one whose license and scope of privileges within a hospital allow patient care to be provided "without direction or supervision." Likewise, the new Medicare conditions of participation state that the medical staff "must be composed of doctors of medicine or osteopathy and, in accordance with State law, may also be composed of other practitioners appointed by the governing body."

In summary then, various legal provisions applicable to licensure and accreditation of hospitals do not presently require medical staff privileges for chiropractors. Indeed, while there are no cases directly on the point, Kansas law has generally been interpreted to specifically prohibit such privileges.



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Immunologic Tests

(Continued from page 87)

using the immunofluorescent technique and flow cytometry.

Evaluation of cell-mediated immunity. Delayed hypersensitivity skin testing should be the first assay performed using two or more common recall antigens (histoplasmin, purified protein derivative (PPD), candida, trichophyton, mumps). Induration at 48 or 72 hours at site of antigen administration of greater than 8 mm is considered a positive test. If the results of this initial evaluation suggest possible alteration in cell-mediated immunity, cell function could be explored in vitro. These studies can assess secondary immunodeficiencies including those associated with chronic infections or malignant states, or monitor immunostimulatory or immunosuppressive therapy.

In vitro cell mediated immunity tests involve the proliferation responses of blood mononuclear cells to mitogens, antigens, or allogenic cells. The most commonly used mitogens are phytohemagglutinin, concanavalin A, and pokeweed mitogen; the first two are primarily T cell mitogens, whereas the latter is a T and B cell mitogen.

Conclusion

Understanding the indications and limitations of immunologic laboratory tests is important in the diagnosis and treatment of many immunologic diseases. Knowledge of the specificity of the various tests is essential in matching a test to the disease process in question. Moreover, the quality of the specimen provided and reputation of the laboratory processing the specimen should be scrutinized when the results are interpreted.

Suggested Readings

1. Katz P: Clinical and laboratory evaluation of the immune system. *Med Clin North Am* 69:453-464, 1985.
2. Greico MH, Meriney DK: *Immunodiagnosis for Clinicians: Interpretation of Immunoassays*. Chicago, Year Book Medical Publishers, pp 1-416, 1983.
3. Rose NR *et al*: *Manual of Clinical Laboratory Immunology*, Third edition. American Society of Microbiology, pp 1-970, 1986.
4. Bryant NJ: *Laboratory Immunology and Serology*. Philadelphia, W. B. Saunders Co., pp 1-212, 1986.



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Drugs should be referred to by generic names; trade names may follow in parentheses if useful. All **units of measure** must be given in the metric system.

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Council Meeting

Report of Meeting Held February 7, 1987

Franklin G. Bichlmeier, M.D., President, convened the Council on February 7, 1987, at the Holiday Inn Holidome, Salina, beginning at 10:00 a.m. Those present were Drs:

Frank Bichlmeier, President
Mark Bell
F. Calvin Bigler
John Blank
L. Theil Bloom
Kenneth Boese
John Brockhouse
Clair C. Conard
Victor Eddy
James Gardner
Charles Glazzard
Jim Gleason
Donald Goering
Frank Griffith
Donald Hatton
Herman Hiesterman
Paul Kindling
David Leitch
Stephen Miller
John Rand Neuenschwander

Daniel Pauls
Eugene Pearce
Katherine Pennington
Terry Poling
Ed Rathbun
Ivan Rhodes
Timothy Scanlan
Clifton Schopf
Alex Scott
Richard Siemans
Arthur Snow
G. Rex Stone
Don Tillotson
Henry Travers
Wayne O. Wallace, Jr.
Linda Warren
Roger Warren
Darrell Werth
Donald Wikoff
James Wilson

Also present was Jeff Gleason, UKSM Student and AMA Delegate from KU Student Section.

Present from the Auxiliary were: Mary Belle Boyd, Betty Glover, and Nancy Ramos.

Staff present were: Val Braun, Gary Caruthers, and Jerry Slaughter.

Minutes of the September 20, 1986 meeting were approved.

The *professional liability update* include the following items: (1) Constitutional test of HB 2661. The ruling on the constitutionality of the Collateral Source Rule has not yet been completed. The Insurance Commissioner is currently challenging the standing of the plaintiff to file the suit; (2) Collateral Source Rule ruling is expected this spring; (3) premiums availability and options. Medical Protective currently has 35% of the insurance market and is not planning to increase premiums in 1987. Medical Defense Company has about 10% of the market and received a 60% increase effective January 1, which makes it the most expensive insurance in the state. St. Paul Fire and Marine Insurance Co. has approximately 35% of the market. The company has filed for but has not yet received a rate increase of
(Continued on page 95)

Penicillin Allergy

(Continued from page 80)

with positive skin tests to minor determinant showed only a greater correlation with PPL RAST rather than the minor determinant.⁵² This suggests a lack of standardization for minor determinant RAST.

ELISA: Haan *et al* described an enzyme linked immunosorbent assay (ELISA) for the evaluation of penicillin allergy. They utilized transferrin conjugated benzylpenicillin as the solid phase antigen for the determination of antibodies to benzylpenicilloyl. They did skin tests with PPL and penicillin G. The overall correlation between PPL skin tests and ELISA was found to be 65.8%. The correlation was higher with PPL than with penicillin G.

Cross Reactivity

In a study by Petz⁵³ of 15,708 patients, 701 had a history of allergic reaction to penicillin. Of these, 57 (8.1%) also had reaction to cephalosporin. The incidence of reaction in penicillin non-allergic patients was only 1.9%. This indicates a higher risk in penicillin allergic individuals when given cephalosporin. This may be due to the structural similarity between penicillin and cephalosporin. Both share the highly reactive beta lactam ring and form penicilloyl and cephalooyl groups respectively. Whether cephalosporin equivalents of the minor determinants are formed is not known.⁵⁴

The risk of an immediate hypersensitivity reaction in penicillin allergic individuals treated with cephalosporin is in the range of 5-16% with a mean of 8.1%.⁵⁵ In patients with a positive history of penicillin allergy and a positive PPL skin test, 50% will have an immediate-type hypersensitivity response to cephalosporins.⁵⁶ Cephalosporins should therefore be avoided in such patients. It may be necessary for skin testing to be performed by experienced personnel if cephalosporins are needed.

Desensitization

If no other alternatives to penicillin are available, a cautious desensitization may be attempted. The basic approach is to start with a low dose that does not produce a reaction. Gradually the amount of penicillin administered is increased. Various routes may be used such as oral, sub-cutaneous, intramuscular, and intravenous. Of these, the sub-cutaneous route in an extremity is preferred by these authors. If a reaction occurs, a tourniquet may be

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applied proximal to the injection site and epinephrine infiltrated at the injection site.

Skin testing should always be performed immediately prior to the desensitization procedure as this would indicate the degree of sensitivity. Premedication with antihistamines and corticosteroids should be avoided. There is no evidence that it is helpful, and it may mask mild allergic reactions that would indicate the need to modify the desensitization schedule. Detailed discussion of various desensitization protocols is beyond the scope of this review.

Conclusion

We have reviewed the basics of penicillin allergy. In view of the potential for severe reactions, penicillin should be used cautiously in sensitive patients after thorough evaluation.

A list of the references cited is available from Dr. Neiburger, UKSM-KC, 39th & Rainbow Blvd., Kansas City KS 66103.



Council Meeting
(Continued from page 93)

65%. A change to six-month policies has also been requested. St. Paul currently is not writing any new business in the state. PHICO (Pennsylvania Casualty) is in the process of reducing its penetration in the market. It is writing only groups of 10 or above at the present time. Dr. Bichlmeier also reported that there are currently \$28 million of unfunded claims in the Health Care Stabilization Fund.

The 1987 *Legislative Update* included a review of the status of some 25 health related legislative bills which are closely monitored by KMS, including SB 35, which includes several technical amendments to HB 2661.

Ivan E. Rhodes, M.D., Chairman of the *Impaired Physicians Committee*, reported that the Committee is in the final stages of finalizing an agreement with the Healing Arts Board which in accordance with HB 2661 will extend to the Committee a quasi-official standing. The Committee will have the authority to investigate and refer to treatment physicians reported by the public or referred by the Board. The agreement provides for financial support and preserves the confidentiality aspect of the Program. Only those physicians who refuse to comply with the Program will be reported to the Board by name. The records would be maintained in the KMS Office and would not be subject to subpoena. The agreement would allow the Committee to authorize Councilors and/or local county medical societies to investigate matters on behalf of the KMS.

Healing Arts Board Issues: (1) No opinion has yet been received from the Attorney General on whether chiropractors may use the term "chiropractic physician"; (2) With regard to the physician assistant prescribing, Council reaffirmed the KMS present policy of opposing the extension of authority to prescribe prescription drugs to nurses, PAs, and other non-physician personnel.

Roger D. Warren, M.D., Chairman, gave the *KaMPAC report*. He reviewed the financial report and encouraged physicians and spouses to continue their support of local legislators and KaMPAC.

Jimmie A. Gleason, M.D., reported that the Committee has selected the Physicians Health Management Corporation of Ohio to conduct the feasibility study for an *Alternative Delivery System* in Kansas. The results of the report should be available at the next Council meeting.

Dr. Bichlmeier reported that *unified membership* with AMA continues to be on the agenda. KMS suffered a \$58,000 dues decrease during 1986 because of losses in membership. An opinion survey

(Continued on page 102)

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Spinal Anesthesia

(Continued from page 84)

neurologic symptoms and hemodynamic changes following this block usually occur after inadvertent intravenous administration or rapid uptake of the local anesthetic. The central nervous system symptoms are usually heralded by excitement, disorientation, and incoherent speech; they can be followed by convulsions. Cardiovascular signs of hypotension, myocardial depression, and peripheral vasodilation are also known to occur.

Total spinal anesthesia following intercostal nerve block has been previously reported.¹⁻⁵ The usual signs include sudden hypotension, bradycardia, and apnea. The duration of the block in this case and the time to return of consciousness, motor function, and sensation are consistent with spinal anesthesia.¹¹

Several mechanisms have been postulated to explain total spinal anesthesia following intercostal nerve blocks.^{1, 4, 7, 12, 13} Subarachnoid deposition of local anesthetics can occur through inadvertent placement of the needle through an intervertebral foramen or from puncturing a long dural cuff. The dural cuff surrounding the intercostal nerves may extend 6-8 centimeters from the intervertebral foramen.¹²

Summary

This case of total spinal anesthesia following intercostal nerve block demonstrates that the blood pressure fall following this block may not be sud-

den. If unrecognized, this complication may present signs that can be confused with other hemodynamic disorders. Appropriate treatment includes oxygen, vasopressors, and volume replacement as indicated.

References

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2. Gallo JA *et al*: Complications of intercostal nerve blocks performed under direct vision during thoracotomy: A report of two cases. *J Thorac Cardiovasc Surg* 86:628-630, 1983.
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5. Moore MC, Reiton JA: Sudden total spinal block after intraoperative intercostal injections: A case report. *Anesthes Rev* 8:36-38, 1978.
6. Baraka A *et al*: Cardiovascular collapse following intercostal block with bupivacaine in a patient under general anesthesia. *MEJ Anesth* 7:229-231, 1983.
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10. Casey WF: Respiratory failure following intercostal nerve blockade. *Anesthesia* 39:351-354, 1984.

A list of the other references cited is available from Dr. Robinson, Department of Anesthesiology, UKSM-Wichita, 1010 No. Kansas, Wichita KS 67208.



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	cimetidine 400 mg h.s.	23%	34%	43%	66
UK, Ireland, Australia ²	ranitidine 150 mg h.s.	8%‡	14%‡	23%‡	243
	cimetidine 400 mg h.s.	21%	34%	37%	241

*p=0.02

†p=0.01

‡p<0.004

%=life-table estimates

All patients were permitted prn antacids for relief of pain.

These two trials used the currently recommended dosing regimen of cimetidine (400 mg h.s.) and ranitidine (150 mg h.s.). A comparison of other dosing regimens has not been studied.

The studied dosing regimens are not equivalent with respect to the degree and duration of acid suppression or suppression of nocturnal acid.

The superiority of ranitidine over cimetidine in these trials indicates that the dosing regimen currently recommended for cimetidine is less likely to be as successful in maintenance therapy.

Convenient once-a-night dose with a

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Headache, sometimes severe, seems to be related to ranitidine administration. Other side effects have been reported; for a complete listing, see the ADVERSE REACTIONS section in the Brief Summary.

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One tablet at bedtime
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See next page for references and
Brief Summary of Product Information.

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References:

1. Silvis SE, Griffin J, Hardin R, et al: Final report on the United States multicenter trial comparing ranitidine to cimetidine as maintenance therapy following healing of duodenal ulcer. *J Clin Gastroenterol* 1985;7(6):482-487.
2. Gough KR, Korman MG, Bardhan KD, et al: Ranitidine and cimetidine in prevention of duodenal ulcer relapse: A double-blind, randomised, multicentre, comparative trial. *Lancet* 1984;ii:659-662.
3. Data available on request, Glaxo Inc.

ZANTAC[®] 150 Tablets
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BRIEF SUMMARY OF PRODUCT INFORMATION

The following is a brief summary only. Before prescribing, see complete prescribing information in ZANTAC[®] product labeling.

INDICATIONS AND USAGE: ZANTAC[®] is indicated in:

1. Short-term treatment of **active duodenal ulcer**. Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer**. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD)**. Symptomatic relief commonly occurs within one or two weeks after starting therapy and is maintained throughout a six-week course of therapy.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC[®] is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: Symptomatic response to ZANTAC[®] therapy does not preclude the presence of gastric malignancy.

Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see **DOSE AND ADMINISTRATION**). Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

False-positive tests for urine protein with Multistix[®] may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Although recommended doses of ZANTAC do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Lack of experience to date precludes recommending ZANTAC for use in children or pregnant patients. Since ZANTAC is secreted in human milk, caution should be exercised when administered to a nursing mother.

ADVERSE REACTIONS: Headache, sometimes severe, seems to be related to ZANTAC[®] administration. Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

In normal volunteers, SGPT values were increased to at least

twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

There have been rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

DVERDSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSE AND ADMINISTRATION: Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

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Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg twice a day.

GERD: The current recommended adult oral dosage is 150 mg twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with ZANTAC, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: ZANTAC[®] 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

ZANTAC[®] 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NDC 0173-0344-42) and unit dose packs of 100 tablets (NDC 0173-0344-47).

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

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Epilepsy

(Continued from page 83)

Acknowledgements

Robert Bugg, Director of Vehicles for the State of Kansas, and Mrs. Geraldine Urich of his office reviewed the manuscript for accuracy concerning the policies of the Kansas Division of Vehicles.

A list of references cited is available on request from Dr. Walsh, Dept. of Pediatrics, UKSM-KC, 39th & Rainbow Blvd., Kansas City KS 66103.



Abuse of the Elderly

The AMA Council on Scientific Affairs reports that as many as 10% of America's elderly may suffer some kind of abuse. According to the report, "... the states spend an average of \$22/child for protective services, only \$2.90 is spent for each elderly person." It is estimated that the incidence of abuse of the elderly is only slightly less prevalent than child abuse, yet while one-third of child abuse incidents are reported, only one-fifth of the cases of elderly abuse are reported.

Physicians who treat elderly patients should be alert to signs of abuse and identify those who may have been abused; take steps to prevent additional injury; establish a therapeutic alliance with family members; comply with state reporting laws; and make use of community resources that can benefit the victim.



A PERSONAL VIEW

And We Shall Be Led By Hindsight . . .

JOHN RAND NEUENSCHWANDER, M.D., *Hoxie*

MODERN MEDICINE seems obsessed with the quixotic pursuit of accuracy and precision. New technology, more nearly perfect than the body it measures, becomes obsolete before it becomes affordable. Our office glucometer is checked by the hospital lab that bows to a reference lab calibrated by precisely prepared samples. Plain films are further defined by CT and superseded by NMR. This effort could be admirable if our patients and government could afford it, but we are assured they cannot.

I recommend that payment for procedures be denied unless confirmed by less precise technology: Check a T₄ by PBI. Compare CT to plain films. Don't pay for a lab FBS unless confirmed by glucometer. This will encourage more cost-effective and appropriate use of technology. If payment denial is only retrospective, quality of care becomes moot, malpractice issues are avoided, and cost savings are maximized.

Although at first glance preposterous, this strategic retreat from obfuscation could extend to all of medical practice. Ideally, each hospital admission would be later approved by a physician with no knowledge of the patient. The reviewer should be oblivious to the patient's past history, prior condition, compliance, concerns, family and social milieu, and recent hospital or office care.

It's being done? Peer Review Organization? Mmmm . . . love the acronym . . . "PRO." A 15-minute chart review declared "quality assurance" for a 20-year doctor-patient relationship? That's a bit arrogant, but I'll bet that with federal pressure it would be accepted.

Editor's Note: The opinions expressed in "A Personal View" are that — personal views of individual KMS members. KANSAS MEDICINE welcomes such expressions of opinion and denies any legal responsibility for their content.

We must admit, a medical care decision made within an ongoing, concerned physician-patient relationship smacks of collusion. The injection of unrelated and disinterested parties into this decision makes it less accurate but more . . . democratic.

We'll support such efforts, of course.

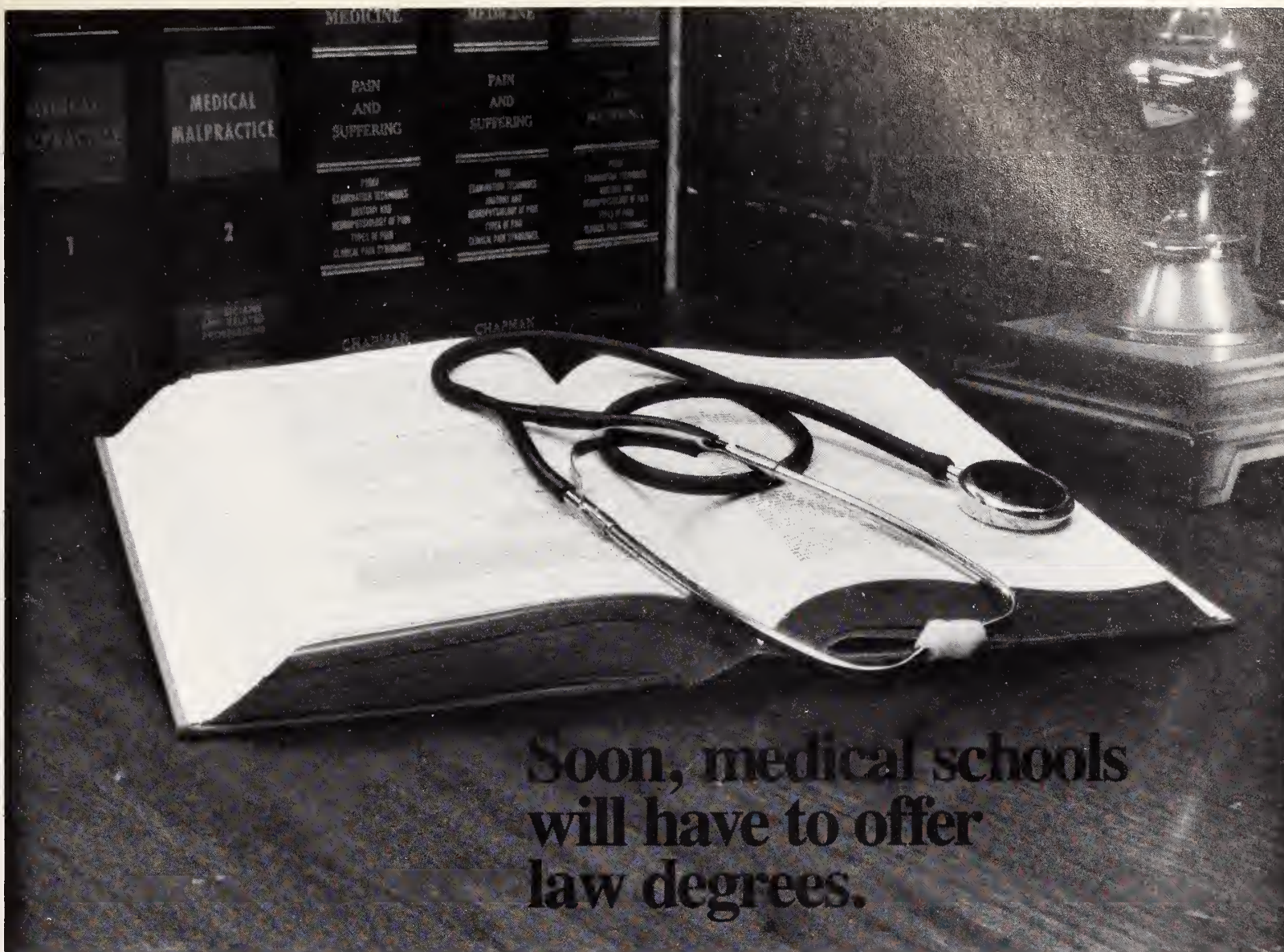
For our patients' benefit . . . 

CORRECTION

The author has advised us of an error in the article, "Ribavirin: Case Reports & Discussion," published in the February issue of KANSAS MEDICINE. On page 45, line four of the section "Administration" should read ". . . water, yielding a final concentration of 20 mg/ml."

KANSAS MEDICINE regrets this error and any confusion it may have caused.





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PHYSICIAN WANTED for rapidly growing ambulatory care center in a town with population of approximately 45,000. Need coverage of 25-30 hrs/week including some evenings and weekends. Reply to Healthcare Designs Systems, P.O. Box 2442, Hutchinson KS 67504, or call 316-662-0709 or 800-255-1382.

Own your practice in one year. Young internist or Boarded F.P. sought to assume busy F.P. practice in Johnson County. For particulars, write Box #1-0387, c/o KANSAS MEDICINE, 1300 Topeka Ave., Topeka KS 66612.

RADIOLOGY: A progressive 36-bed hospital with 100-bed long term care unit in a rural community is seeking a radiologist 4 days/week. 25-50 miles from 4 medium to large metropolitan areas. Large recreational lake nearby. Would consider \$60,000 guaranteed salary and time share with another nearby hospital. Contact Gary Fowler, Administrator, 913-774-4340; Jefferson County Memorial Hospital & Geriatric Center, Route 1, Box 1, Winchester KS 66097.

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PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.⁵

Low-dose control of menopausal symptoms*

PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

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Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

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vasomotor symptoms

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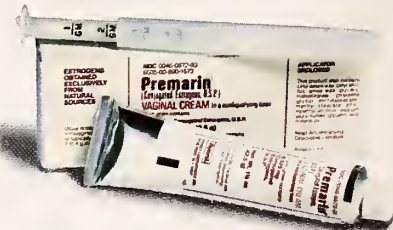
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For atrophic vaginitis

PREMARIN® (Conjugated Estrogens)

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Cream

0.625mg/g



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)

PREMARIN® Brand of conjugated estrogens tablets, USP

PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1 ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA.

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17 α -dihydroequilin, together with smaller amounts of 17 α -estradiol, equilenin, and 17 α -dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe vasomotor symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with

caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

- Increased sulfolobomorphine retention.
- Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.
- Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by T₄ by column, or T₄ by radioimmunoassay. Free T₃ resin uptake is decreased, reflecting the elevated TBG; free T₄ concentration is unaltered.
- Impaired glucose tolerance.
- Decreased pregnanediol excretion.
- Reduced response to meprobamate test.
- Reduced serum folate concentration.
- Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. Given cyclically for short-term use only. For treatment of moderate to severe vasomotor symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. Given cyclically: Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three- to six-month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

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Council Meeting

(Continued from page 95)

of KMs membership to determine continued support for unification has been authorized.

David A. Leitch, M.D., stated he will introduce a resolution to repeal unification. He called attention to his article about unification which will appear in the February issue of KANSAS MEDICINE. Dr. Leitch also expressed a need for verification of delegates in attendance at the House of Delegates meetings.

Staff report regarding *KMS Services, Inc.* included: KMS loaned \$15,000 for development of operations, which include selling of the HCFA 1500 Uniform Claim Form, and the Professional Liability Insurance Premium Finance Plan; administrative contracts have been signed with MEDISERVE; clerical and administrative services have been offered to specialty societies; group purchasing, medical payment system and other types of programs are being investigated; ideas for alternative programs were solicited from the Councilors.

KMS Budget: The Council authorized the transfer of \$3,000 in unclaimed Blue Shield refunds to the Professional Liability Fund; the Officers and Directors Professional Liability Insurance premiums have increased from \$3,000 to \$7,000; the Council approved the revised budget showing a deficit of some \$24,000.

The Council reviewed the resolution regarding the *Alliance of State Physician Networks*. Kansas-Champus region is not under consideration for a demonstration project at this time.

Linda A. Warren, M.D., reported on the *Young*

Physicians Section, in the absence of Jay Schukman, M.D. The Council supports the formation of a steering committee to determine interest in a Young Physicians Section and to submit a resolution to implement the Section if sufficient interest in identified.

The Council reaffirmed the policy of charging a registration fee for the *Annual Meeting*. The fee was set at \$15.00

Staff was directed to learn of the extent of the mailing list for the Blue Shield magazine, *Perspective*.

Physicians were encouraged to contact their Congressional members concerning the HCFA proposal to include radiologists, anesthesiologists and pathologists in the DRG payment system to hospitals. Staff reported that Medicare *legislative hearings* will be conducted in Wichita on February 14 and in Topeka on February 16, and encouraged physicians to attend those meetings and/or provide written comments concerning the *Medicare* program. KMS has requested the Kansas Congressional delegation to co-sponsor an AMA-introduced resolution to oppose this issue.

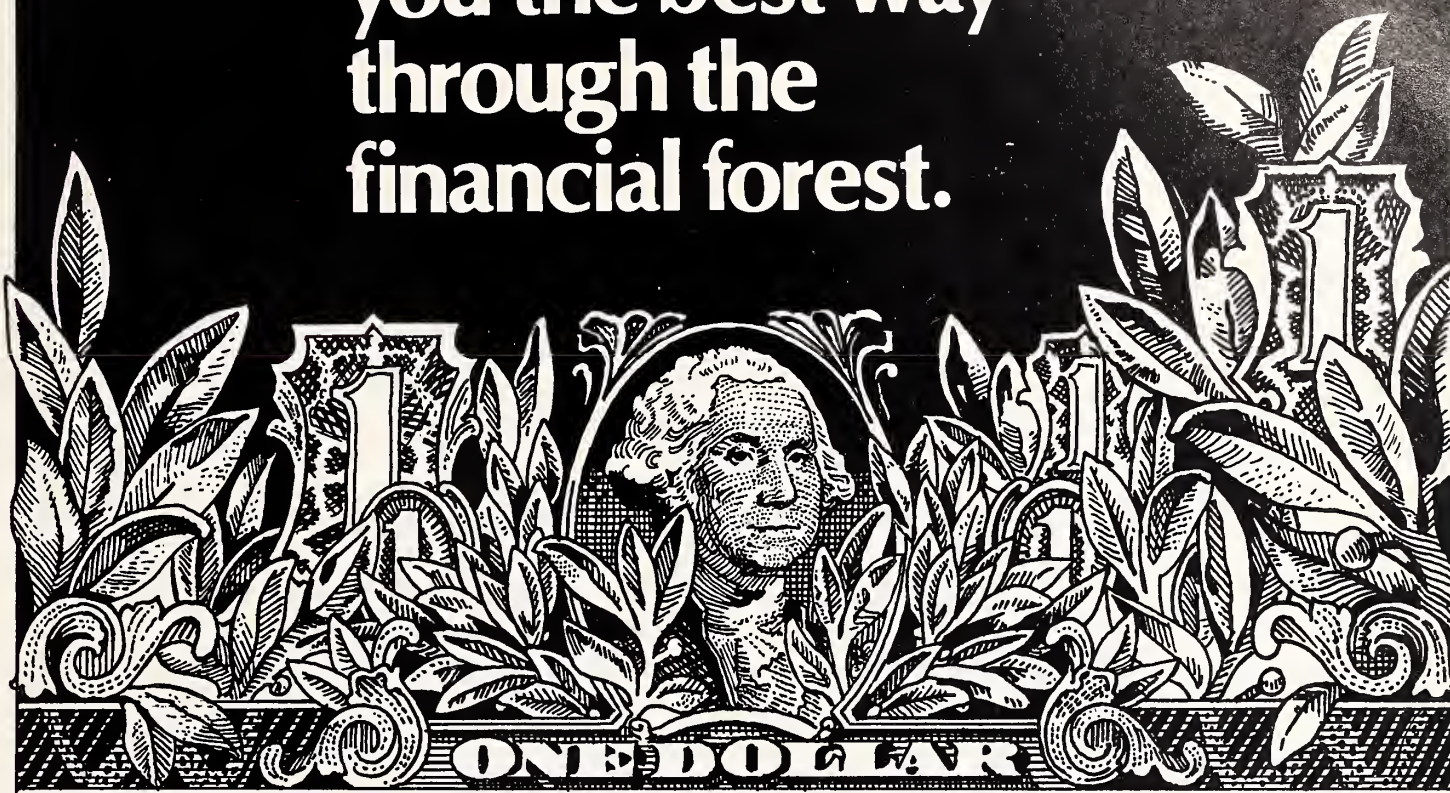
James W. Wilson, M.D., expressed his appreciation to KaMPAC for providing financial support for his state *legislative race*. Dr. Wilson is now Councilor for District 19.

The *next meeting* of the Council will be on April 11, 1987, at the Topeka Holidome beginning at 10:00 a.m.

There being no further business, the meeting adjourned at 12:00 Noon.



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American Heritage	6	24.00	18.00	18.00	Harpers Magazine	12	18.00	9.97	9.97	Popular Science	12	13.94	7.97	7.97
Amer. Photog. [Special: 8 iss.]		5.98	5.98		Health [Special: 9 issues]		8.97	8.97		#PRACTICAL HOMEOWNER	9	12.97	6.50	9.97
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ATLANTIC CITY	13	15.16	9.95		Home Mechanix	12	11.94	8.97	8.97	Reader's Digest	12	15.41	15.41	15.41
Atlantic Monthly	12	9.95	9.95	9.95	The Homeowner [Special: 6 iss.]		8.97	8.97		#Redbook	12	11.97	6.97	11.97
Audio	12	19.94	9.97	9.97	Home Viewer	12	18.00	11.97	11.97	Road and Track	12	19.94	14.99	14.99
AUTOMOBILE	12	24.00	12.00		Hot Rod	12	13.94	8.97	8.97	Robb Report	12	65.00	65.00	
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Basketball Digest	8	9.95	7.97	7.97	#House Beautiful	12	15.97	7.99	15.97	#RUNNER'S WORLD	12	19.95	10.00	12.97
#Better Homes & Gdns	12	14.00	7.00	14.00	Inc.	12	24.00	12.00	12.00	Sail	12	21.75	21.75	21.75
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Field & Stream	12	15.94	7.97	7.97	Outdoor Life	12	13.94	7.97	7.97	Video	13	12.00	8.97	8.97
Fifty Plus	12	15.00	11.97	11.97	Outside	10	16.00	12.00	8.97	Video Review	12	12.00	6.97	6.97
Financial World	26	41.95	24.94		Ovation	12	18.00	10.00	10.00	Vogue	12	24.00	21.00	
Flying	12	18.98	15.97	15.97	PARENTING:	10	18.00	9.00		W Magazine	26	26.00	23.00	17.95
Food and Wine	12	20.00	10.00	15.00	Parents	12	18.00	9.00		Weight Watchers	12	13.97	11.97	11.97
Football Digest	10	12.95	12.95	7.97	Penthouse	12	36.00	30.00	30.00	Woman's Day	17	16.97	16.97	16.97
Forbes	28	45.00	45.00	29.95	People	52	56.00	56.00	30.95	Women's Sports	12	12.95	7.97	8.95
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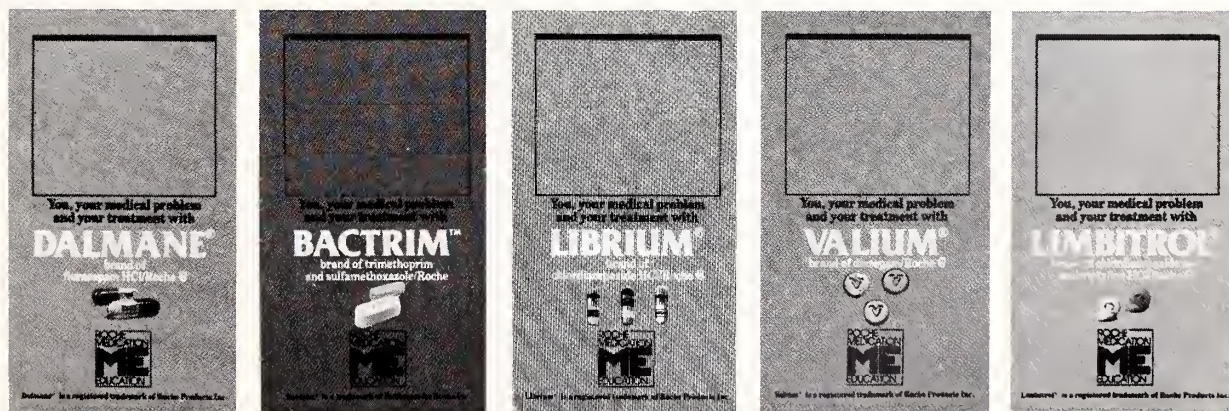


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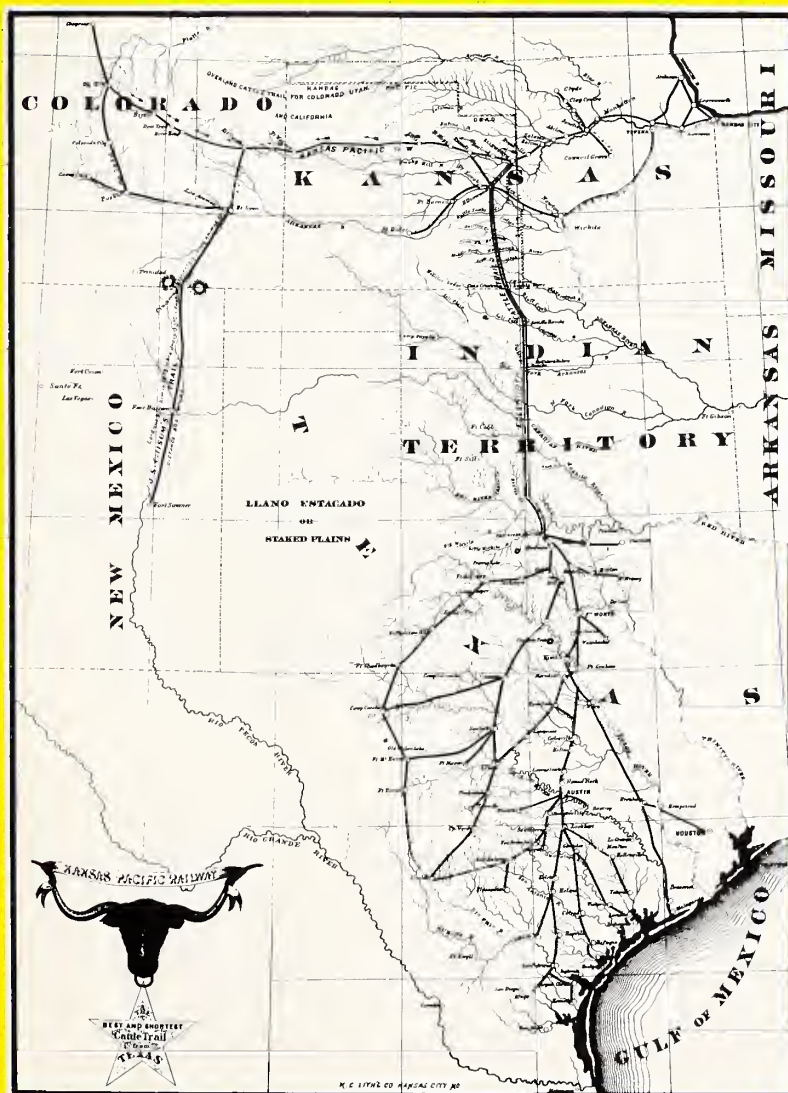
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Volume 88, Number 4, April 1987 ISSN 8755-0059



A Personal View Response	110
BAEP in Dizziness	121
Foreign Bodies in UGI Tract	116
HSV & HPV in Cervical Cancer	113
KFMC Update	112
KMS Newsletter	120a
Post-Splenectomy Sepsis	119

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Volume 88, Number 4, April 1987

Contents

Scientific Articles

- The Role of HSV & HPV in Cervical Cancer — Robert Beach, Ph.D. and Charles R. King, M.D., Kansas City, Kansas
There is mounting evidence that cervical cancer is associated with a sexually transmitted agent. High risk HSV and HPV positive women need early identification and treatment 113
- Foreign Bodies in the Upper GI Tract — Asghar M. Chaudhary, M.D., Shawnee Mission
Foreign body ingestion is common and requires skilled and careful treatment to keep morbidity and mortality to a minimum 116
- Post-Splenectomy Sepsis — Mary L. Barnes; Kay L. Saving, M.D. and Tribhawan S. Vats, M.D., Kansas City, Kansas
Although splenectomy is considered a technically simple surgical procedure, its known long-term risks include the major one of sepsis 119
- Brainstem Auditory Evoked Potentials in Dizziness — I. Ahmed, M.D., Kansas City, Missouri
Dizziness is a common symptom, and BAEP may be useful when the diagnosis is unclear 121

Miscellaneous

- A Personal View — A Response to "Who Determines Quality?" — Calvin R. Openshaw, M.D., Hutchinson ... 110
- Auxiliary News 106
- Classified Advertisements 133
- Cover Story 105
- Editorial Comment: *The Right Stuff* 126
- KFMC Update 112
- KMS Newsletter 120a
- Medicina et Lex: *Patient Records* — Wayne T. Stratton, J.D., Topeka 127
- Nominating Committee Report 108
- President's Message 125
- Vox Dox 135

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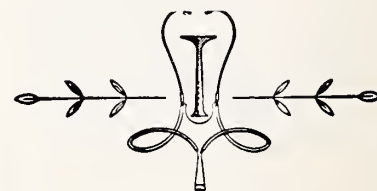
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Cover Story

Map: Baughman's Kansas in Maps, courtesy of the Kansas State Historical Society.

The cattle drives of the 1860s and 70s meant simply getting the animals from Texas to a point of more efficient transportation. Railroads were increasingly pushing south and west. The towns that brought them together became the focal points and created a lurid chapter in the state's history (too broad, in fact, to be given full justice here).

Earlier drives headed toward the Mississippi, later through Indian Territory (Oklahoma), northwest Arkansas and the Ozarks to Sedalia and St. Louis, a debilitating trek for the cattle, thus a financial loss to the ranchers, drovers, and entrepreneurs. The arrival of the Kansas Pacific Line (at other times known as the Kansas Division, Union Pacific) and the Santa Fe south along the Arkansas made Kansas an easier and more profitable destination.

Probably the first, and certainly the best known, figure on the Kansas scene was Jesse Chisholm, half-Indian trader, who began, in 1865, to bring cattle to his home area south of Wichita along the trail he used in trading. Progressively, towns along the railroads gained various degrees of prominence as "cow towns." The Kansas Pacific promotional map chose to call the main trail "The Ellsworth Trail," relegating the Chisholm to a short trail well to the west. At risk of offending that city, however, we mention that everyone else seemed to call it the Chisholm Trail which name came to have virtually generic coverage for all the trails as time passed.

More than transportation problems plagued the effort. The herds were subject to fever ("Spanish Fever" to the Texans, "Texas Fever" to all others) which destroyed the animals and worried Kansans with the risk of spread to local animals. The 1861 Kansas Legislature did prohibit Texas cattle entirely but that was unworkable and, in 1867, it limited them to west of the 6th Principal Meridian. (Abilene was, in fact, east of the line but no one seemed to notice.) Finally, progress took over. Railroads pushed south shortening the drives. Farmers fenced their land, blocking the trails. Domestic beef production took its place along with crop production as state enterprises. Legislative restrictions increased. By the mid-80s, the drives were over.

But there is one interesting sociologic note pointed out by Kenneth S. Davis in his "Kansas — A History." Although cow towns were notorious for their rowdy elements, there were, all the time, separate arcas where the stable, conforming (and less interesting) people lived — the immigrants and their descendants who came to establish homes. For all the lurid history of the relatively brief cattle drive days, these were the people who gave the towns and state their real character. — D.E.G.



AUXILIARY NEWS

Dear Doctor:

I have chosen to write only once during my term as president so that I can present a message of interest to you.

Our year has been busy and successful, and I feel we have achieved our primary goal — the promotion of your welfare. Each city or town with an active auxiliary has benefited from our efforts to improve the health and quality of life of all of its citizens. We have promoted health education, encouraged participation in activities that meet health needs, and worked in coalition with other organizations to improve Kansas communities. In addition, we have taken an active role in legislative matters and were instrumental in the election of people who will support the medical positions on issues.

It has been reported that physicians fail to keep their senators and congressmen adequately informed on medical issues. Perhaps we can help. If you are too busy to write or call, ask your spouse to do it for you. Malpractice is only one of the problems you face; government regulations are high on the list of matters that need your attention, too.

My theme this year was "Teenage Pregnancy"; I wish I could report that we have solved that problem. However, we have educated ourselves on this and related matters, and will support a program in schools that was promoted at our Fall Conference. We have identified sources of counseling, medical care, and access to the adoption process for those who need help.

Another major Auxiliary function is AMA-ERF, which benefits our medical school. To assist our efforts this year, the Harvey County Medical Society has mounted a blue topaz stone, cut and donated by Lee S. Fent, M.D. It is surrounded by three diamonds and is valued at \$1,300. The Harvey County Auxiliary has donated a queen size hand quilted quilt designed by Esther Harms (Wilmer). Chances on these two items are available for \$1.00 each, and the winners will be drawn at State Convention. You may send your money to me, and I will do the paper work. You've always been generous to this good cause, and I'm sure you will wish to continue.

It has been my privilege this year to attend your Executive Committee and Council meetings where I've had the opportunity to learn about the problems you face and the work it takes to run your organi-

zation. We of the Auxiliary are pleased to work with you to improve the physician's professional environment.

Now I want to ask a favor of you. There are many spouses who aren't members of the Auxiliary. Please ask them to join us — or YOU can send their dues to me — \$25.00 for state and national, plus local dues if you choose. They will receive periodicals from the State and National organizations, and through the local auxiliary they will find many valuable friendships. You will have given your spouse a great gift and will also help to make us more effective in our efforts for your society.

There is much more I could say because we're doing so much! I have enjoyed my year as President of the Kansas Medical Society Auxiliary and I appreciate the support you have given to us.

Sincerely,

Betty Glover (Richard M.)

KMSA President



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Nominating Committee Report

The KMS Nominating Committee has submitted the following slate of candidates for offices for the election to be held at the annual meeting April 30-May 3, 1987, in Manhattan:

PRESIDENT: Donald W. Hatton, M.D., Lawrence
PRESIDENT ELECT: Terry L. Poling, M.D., Wichita

FIRST VICE PRESIDENT: Alex Scott, M.D., Junction City

SECOND VICE PRESIDENT: Francis R. Applegate, Jr., M.D., Hays; Arthur D. Snow, Jr., M.D., Shawnee Mission; Roger D. Warren, M.D., Hanover

CONSTITUTIONAL SECRETARY: Katherine Pennington, M.D., Wichita

TREASURER: Larry Rotert, M.D., Topeka; Donald R. Brada, Hutchinson

SPEAKER: Larry R. Anderson, M.D., Wellington; Ivan E. Rhodes, M.D., Wichita

VICE SPEAKER: Kenneth L. Derrington, M.D., Shawnee Mission; Edwin D. Rathbun, M.D., Liberal

AMA DELEGATE: Lew W. Purinton, M.D., Wichita

AMA ALTERNATE: F. Calvin Bigler, M.D., Garden City

AMA DELEGATE: Jimmie A. Gleason, M.D., Topeka

AMA ALTERNATE: Stephen F. Miller, M.D., Parsons

AMA DELEGATE: Linda D. Warren, M.D., Hanover

AMA ALTERNATE: Jay S. Schukman, M.D., Great Bend; Stuart C. Averill, M.D., Topeka

AMA DELEGATE: Warren E. Meyer, M.D., Wichita

AMA ALTERNATE: John P. Brockhouse, M.D., Emporia; Wayne O. Wallace, Jr., M.D., Atchison

The KMS Nominating Committee encourages additional nominations, which may be presented by delegates at the annual meeting.



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Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other anti-hypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

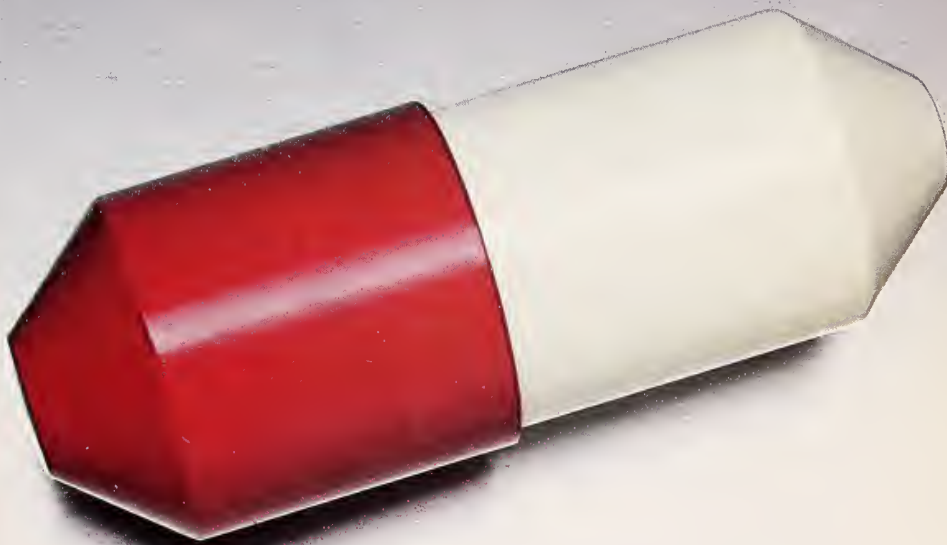
Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ:L42

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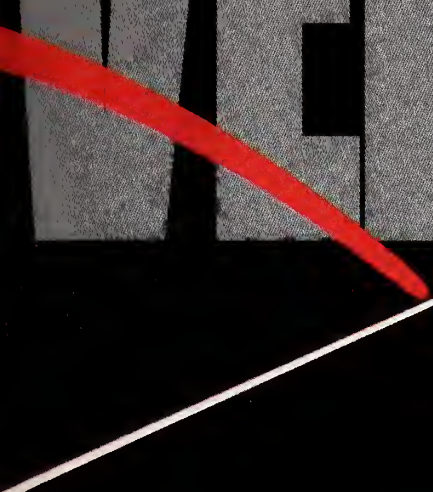
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Insulin levels are rapidly elevated in response to a meal, then return promptly to basal levels after the meal challenge subsides.

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Rapidly metabolized and excreted, with an excellent safety profile.¹ As with all sulfonylureas, hypoglycemia may occur.

In concert with diet in non-insulin-dependent diabetes mellitus

Glucotrol[®]
(glipizide) 5-mg and 10-mg
Scored Tablets 

**SYNCHRONIZED
SULFONYLUREA THERAPY**



Please see brief summary of Glucotrol[®] (glipizide) prescribing information on next page.

ROERIG 
A division of Pfizer Pharmaceuticals
New York, New York 10017

Reference:

1. Sachs R, Frank M, Fishman SK. Overview of clinical experience with glipizide. In *Glipizide: A Worldwide Review*. Princeton, NJ, Excerpta Medica, 1984. pp 163-172.

GLUCOTROL® (glipizide) Tablets

Brief Summary of Prescribing Information

INDICATIONS AND USAGE: GLUCOTROL is indicated as an adjunct to diet for the control of hyperglycemia in patients with non-insulin-dependent diabetes mellitus (NIDDM, type II) after an adequate trial of dietary therapy has proved unsatisfactory.

CONTRAINDICATIONS: GLUCOTROL is contraindicated in patients with known hypersensitivity to the drug or with diabetic ketoacidosis, with or without coma, which should be treated with insulin.

SPECIAL WARNING ON INCREASED RISK OF CARDIOVASCULAR MORTALITY: The administration of oral hypoglycemic drugs has been reported to be associated with increased cardiovascular mortality as compared to treatment with diet alone or diet plus insulin. This warning is based on the study conducted by the University Group Diabetes Program (UGDP), a long-term prospective clinical trial designed to evaluate the effectiveness of glucose-lowering drugs in preventing or delaying vascular complications in patients with non-insulin-dependent diabetes. The study involved 823 patients who were randomly assigned to one of four treatment groups (Diabetes, 19, supp. 2:747-830, 1970).

UGDP reported that patients treated for 5 to 8 years with diet plus a fixed dose of tolbutamide (1.5 grams per day) had a rate of cardiovascular mortality approximately 2-1/2 times that of patients treated with diet alone. A significant increase in total mortality was not observed, but the use of tolbutamide was discontinued based on the increase in cardiovascular mortality, thus limiting the opportunity for the study to show an increase in overall mortality. Despite controversy regarding the interpretation of these results, the findings of the UGDP study provide an adequate basis for this warning. The patient should be informed of the potential risks and advantages of GLUCOTROL and of alternative modes of therapy.

Although only one drug in the sulfonylurea class (tolbutamide) was included in this study, it is prudent from a safety standpoint to consider that this warning may also apply to other oral hypoglycemic drugs in this class, in view of their close similarities in mode of action and chemical structure.

PRECAUTIONS: Renal and Hepatic Disease: The metabolism and excretion of GLUCOTROL may be slowed in patients with impaired renal and/or hepatic function. Hypoglycemia may be prolonged in such patients should it occur.

Hypoglycemia: All sulfonylureas are capable of producing severe hypoglycemia. Proper patient selection, dosage, and instructions are important to avoid hypoglycemia. Renal or hepatic insufficiency may increase the risk of hypoglycemic reactions. Elderly, debilitated or malnourished patients and those with adrenal or pituitary insufficiency are particularly susceptible to the hypoglycemic action of glucose-lowering drugs. Hypoglycemia may be difficult to recognize in the elderly or people taking beta-adrenergic blocking drugs. Hypoglycemia is more likely to occur when caloric intake is deficient, after severe or prolonged exercise, when alcohol is ingested, or when more than one glucose-lowering drug is used.

Loss of Control of Blood Glucose: A loss of control may occur in diabetic patients exposed to stress such as fever, trauma, infection or surgery. It may then be necessary to discontinue GLUCOTROL and administer insulin.

Laboratory Tests: Blood and urine glucose should be monitored periodically. Measurement of glycosylated hemoglobin may be useful.

Information for Patients: Patients should be informed of the potential risks and advantages of GLUCOTROL, of alternative modes of therapy, as well as the importance of adhering to dietary instructions, of a regular exercise program, and of regular testing of urine and/or blood glucose. The risks of hypoglycemia, its symptoms and treatment, and conditions that predispose to its development should be explained to patients and responsible family members. Primary and secondary failure should also be explained.

Drug Interactions: The hypoglycemic action of sulfonylureas may be potentiated by certain drugs including non-steroidal anti-inflammatory agents and other drugs that are highly protein bound, salicylates, sulfonamides, chloramphenicol, probenecid, coumarins, monoamine oxidase inhibitors, and beta adrenergic blocking agents. *In vitro* studies indicate that GLUCOTROL binds differently than tolbutamide and does not interact with salicylate or dicumarol. However, caution must be exercised in extrapolating these findings to a clinical situation. Certain drugs tend to produce hyperglycemia and may lead to loss of control, including the thiazides and other diuretics, corticosteroids, phenothiazines, thyroid products, estrogens, oral contraceptives, phenytoin, nicotinic acid, sympathomimetics, calcium channel blocking drugs, and isoniazid. A potential interaction between oral miconazole and oral hypoglycemic agents leading to severe hypoglycemia has been reported. Whether this interaction also occurs with the intravenous, topical, or vaginal preparations of miconazole is not known.

Carcinogenesis, Mutagenesis, Impairment of Fertility: A 20-month study in rats and an 18-month study in mice at doses up to 75 times the maximum human dose revealed no evidence of drug-related carcinogenicity. Bacterial and *in vivo* mutagenicity tests were uniformly negative. Studies in rats of both sexes at doses up to 75 times the human dose showed no effects on fertility.

Pregnancy: Pregnancy Category C: GLUCOTROL (glipizide) was found to be mildly fetotoxic in rat reproductive studies at all dose levels (5-50 mg/kg). This fetotoxicity has been similarly noted with other sulfonylureas, such as tolbutamide and tolazamide. The effect is perinatal and believed to be directly related to the pharmacologic (hypoglycemic) action of GLUCOTROL. In studies in rats and rabbits no teratogenic effects were found. There are no adequate and well controlled studies in pregnant women. GLUCOTROL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Because recent information suggests that abnormal blood glucose levels during pregnancy are associated with a higher incidence of congenital abnormalities, many experts recommend that insulin be used during pregnancy to maintain blood glucose levels as close to normal as possible.

Nonteratogenic Effects: Prolonged severe hypoglycemia has been reported in neonates born to mothers who were receiving a sulfonylurea drug at the time of delivery. This has been reported more frequently with the use of agents with prolonged half-lives. GLUCOTROL should be discontinued at least one month before the expected delivery date.

Nursing Mothers: Since some sulfonylurea drugs are known to be excreted in human milk, insulin therapy should be considered if nursing is to be continued.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: In controlled studies, the frequency of serious adverse reactions reported was very low. Of 702 patients, 11.8% reported adverse reactions and in only 1.5% was GLUCOTROL discontinued.

Hypoglycemia: See PRECAUTIONS and OVERDOSEAGE sections.

Gastrointestinal: Gastrointestinal disturbances, the most common, were reported with the following approximate incidence: nausea and diarrhea, one in 70; constipation and gastralgia, one in 100. They appear to be dose-related and may disappear on division or reduction of dosage. Choledastic jaundice may occur rarely with sulfonylureas. GLUCOTROL should be discontinued if this occurs.

Dermatologic: Allergic skin reactions including erythema, morbilliform or maculopapular eruptions, urticaria, pruritus, and eczema have been reported in about one in 70 patients. These may be transient and may disappear despite continued use of GLUCOTROL; if skin reactions persist, the drug should be discontinued. Porphyrin cutanea tarda and photosensitivity reactions have been reported with sulfonylureas.

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia, hemolytic anemia, aplastic anemia, and pancytopenia have been reported with sulfonylureas.

Metabolic: Hepatic porphyria and disulfiram-like alcohol reactions have been reported with sulfonylureas. Clinical experience to date has shown that GLUCOTROL has an extremely low incidence of disulfiram-like reactions.

Endocrine Reactions: Cases of hyponatremia and the syndrome of inappropriate antidiuretic hormone (SIADH) secretion have been reported with this and other sulfonylureas.

Miscellaneous: Dizziness, drowsiness, and headache have been reported in about one in fifty patients treated with GLUCOTROL. They are usually transient and seldom require discontinuance of therapy.

OVERDOSEAGE: Overdosage of sulfonylureas including GLUCOTROL can produce hypoglycemia. If hypoglycemic coma is diagnosed or suspected, the patient should be given a rapid intravenous injection of concentrated (50%) glucose solution. This should be followed by a continuous infusion of a more dilute (10%) glucose solution at a rate that will maintain the blood glucose at a level above 100 mg/dL. Patients should be closely monitored for a minimum of 24 to 48 hours since hypoglycemia may recur after apparent clinical recovery. Clearance of GLUCOTROL from plasma would be prolonged in persons with liver disease. Because of the extensive protein binding of GLUCOTROL (glipizide), dialysis is unlikely to be of benefit.

DOSEAGE AND ADMINISTRATION: There is no fixed dosage regimen for the management of diabetes mellitus with GLUCOTROL; in general, it should be given approximately 30 minutes before a meal to achieve the greatest reduction in postprandial hyperglycemia.

Initial Dose: The recommended starting dose is 5 mg before breakfast. Geriatric patients or those with liver disease may be started on 2.5 mg. Dosage adjustments should ordinarily be in increments of 2.5-5 mg, as determined by blood glucose response. At least several days should elapse between titration steps.

Maximum Dose: The maximum recommended total daily dose is 40 mg.

Maintenance: Some patients may be effectively controlled on a once-a-day regimen, while others show better response with divided dosing. Total daily doses above 15 mg should ordinarily be divided.

HOW SUPPLIED: GLUCOTROL is available as white, dye-free, scored diamond-shaped tablets imprinted as follows: 5 mg tablet—Pfizer 411 (NOC 5 mg 0049-4110-66) Bottles of 100; 10 mg tablet—Pfizer 412 (NOC 10 mg 0049-4120-65) Bottles of 100.

CAUTION: Federal law prohibits dispensing without prescription.

More detailed professional information available on request.

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A PERSONAL VIEW

A Response to "Who Determines Quality?"

CALVIN R. OPENSHAW, M.D.,* *Hutchinson*

MY OLDER friends of the Kansas Medical Society will recognize in me one of the better-credentialed resisters of the process of regulation. I was dragged kicking and screaming into the present day of medical practice.

But now that I am here, I am able to discriminate between regulation based on medical knowledge and the kind of regulation we are provided directly from Federal agencies. I ardently prefer the former!

Conversely, I am not naive enough to think that the government influence is not bleeding through the gauze of physician action in agencies such as KFMC. But at least the gauze offers some hope of preventing exsanguination.

Nor would I accept the imputation that the medical profession is the cause of the money crunch of our nation. We did not write Hill-Burton, nor opt for overcrowded medical schools. We did not even promise the inherent right to the best of medical care. Politicians did these things. However, we did go along.

And now we ARE regulated. If KFMC doesn't do it, the team direct from Washington (HCFA) will.

The differences in "documentation requirements and the practice style of solo vs group, rural vs urban, and fee-for-service vs pre-paid physicians"

are well evident to the KFMC reviewers. They are NOT acceptable in Washington, however. We are directed to apply uniform guidelines, and the reviewing we do is, in turn, reviewed at higher levels.

I am astonished at criticism of physicians' (read: "reviewers' ") handwriting! The charts that we see that lack typescript records are often so illegible that we must base decisions on less-than 100% understanding of what the attending physician meant to say.

As to reading the "reams of information" supplied, those sprained eyeballs some of us possess have resulted from strong determination not to miss any of the critical issues.

The diatribe of Drs. Marvel, McCormick, Naloz, and Rattenné contains many errors of fact:

1. First and foremost, any decline in quality and availability of medical care is NOT the fault of KFMC.

2. The Foundation was not "contracted to implement DRGs" (whatever that means). The Foundation was developed by the Kansas Medical Society about 14 years ago in response to the PSRO law, and did many things prior to the DRG move by Congress.

3. Medical expertise exhibited by some reviewers is admittedly not capable of the finer points of ALL specialties. Lots of physicians are needed to do the work — and we all have practices to tend. But the final decisions are arrived at by physicians of high expertise and integrity after considerable thought and discussion. The reviewers that I know readily "punt" charts that prove to be outside of their field of expert knowledge to those better informed in those areas.

In addition to the factual errors, the article contains insults, derogation, innuendos, and insidious statements designed to degrade what is, after all, an organization made up of representative physicians from throughout the state of Kansas.

I summarize my rebuttal as follows:

(Continued on page 135)

* KFMC Reviewer

Editor's Note: The opinions expressed in "A Personal View" are that — personal views of individual KMS members. KANSAS MEDICINE welcomes such expressions of opinion and denies any legal responsibility for their content.

This article was prepared by Dr. Openshaw in response to the "Personal View" presented in the November issue of KANSAS MEDICINE by Dr. James E. Marvel et al critical of the Kansas Foundation for Medical Care. In printing the original opinions as well as responses such as this, we intend to offer our readers the opportunity to express varying opinions in order to encourage a full range of thoughts on medical problems of the day. Editing (as in all "Personal View" contributions) is defined by space requirements and appropriate textual control within legal limits, and the opinions do not necessarily represent those of KANSAS MEDICINE or the Kansas Medical Society.

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KFMC UPDATE

Editor's Note: In keeping with its policy of offering continuing information regarding medical activities, KANSAS MEDICINE introduces a serial offering prepared by G. Rex Stone, M.D., Medical Director of the Kansas Foundation for Medical Care. These articles will keep Kansas physicians abreast of KFMC-related matters.

THE TWO Omnibus Budget Reconciliation Acts of 1986 (COBRA and SOBRA) have mandated several new areas of responsibility for the Kansas Foundation for Medical Care. To assist Kansas physicians in knowing when to expect changes in the review program, those mandates and their implementation status are listed below.

HMO and CMP Review. As of February 20, 1987, the Request for Proposal (RFP) for this program had not been released to HCFA by the Federal Office of Management and Budget. This program is scheduled to be implemented April 1, 1987, but the delay in releasing the RFP makes the April 1st effective date questionable.

Denials for Quality Concerns. This has been put on hold indefinitely pending further development of implementation procedures.

Meeting Review of Certain Elective Procedures and Second Surgical Opinion Program. HCFA has identified 13 procedures, from which the PRO is to select ten. HCFA is in the process of developing the protocol for implementing this program. After the protocol is released, there will be a 90-120 day lead time before review is implemented. Probable earliest start date is June 1, 1987.

Review of Assistant in Cataract Surgery. This review will go into effect for procedures performed on and after March 1, 1987. KFMC distributed the review protocol and criteria for reviewing the need for an assistant in cataract surgery to all involved providers on February 18, 1987.

Readmissions Within 31 Days. This review is to expand identification of possible premature discharges and goes into effect on any PRO contract signed after April 1, 1987. Because of KFMC's contract cycle, this will not become a part of our review program until July 1, 1988.

Hospital-Issued Denial Notices. Revisions to this review process now allow for immediate review of denial notices in which the beneficiary does not agree with the denial. It also requires the PRO to obtain beneficiary, physician, and hospital input before making a determination on the appropriateness of the denial.

If you have questions about these new review activities, or any part of KFMC's review process, please contact the Foundation at 913-273-2552.



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Now the evidence looks better than ever

Significantly reduced risk of endometrial hyperplasia

Endometrial hyperplasia was significantly reduced when progestin was added to PREMARIN therapy for more than ten days a month!⁴ The risk of endometrial hyperplasia may also be reduced through cyclic administration of unopposed, low-dose PREMARIN.

Effect on lipids—an important feature

PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.⁵

Low-dose control of menopausal symptoms*

PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

The most widely used, most extensively studied estrogen worldwide.

PREMARIN®
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Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe
vasomotor symptoms

PREMARIN® (Conjugated Estrogens Tablets)



0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)

PREMARIN® Brand of conjugated estrogens tablets, USP

PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA.

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equestrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17 α -dihydroequilin, together with smaller amounts of 17 α -estradiol, equilin, and 17 α -dihydroequilin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe vasomotor symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

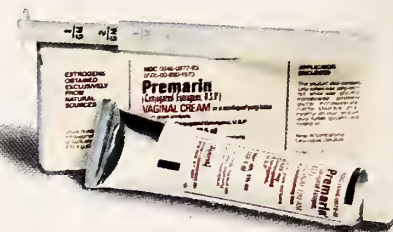
Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with

For atrophic vaginitis

PREMARIN® (Conjugated Estrogens)

Vaginal
Cream

0.625mg/g



caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

- Increased sulfobromophthalain retention.
- Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.
- Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T₄ by column, or T₄ by radioimmunoassay. Free T₃ resin uptake is decreased, reflecting the elevated TBG; free T₄ concentration is unaltered.
- Impaired glucose tolerance.
- Decreased pregnandiol excretion.
- Reduced response to metyrapone test.
- Reduced serum folate concentration.
- Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyoma; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSEAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate to severe vasomotor symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically:* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

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SCIENTIFIC ARTICLES

The Role of HSV & HPV in Cervical Cancer

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THERE IS mounting evidence that cervical cancer is associated with a sexually transmitted agent. For 18 years, Herpes simplex virus (HSV) type 2 has been strongly suspected as such an agent.¹ More recently, human papilloma virus (HPV) has been implicated in cervical dysplasia and neoplasia.² The current state of our knowledge regarding the roles of these viruses as etiological factors in cervical carcinogenesis is discussed here.

If this association is casual, then certain reasonable predictions which have been proposed³ should hold: (1) The epidemiology should be similar to that for cervical cancer; (2) An infection should antedate the diagnosis of cervical neoplasia; (3) The infection should affect the cervix, in particular the squamocolumnar junction; (4) The oncogenicity of various strains should vary; (5) The oncogenic potential of the viruses should be demonstrable *in vitro* and/or in experimental animals; (6) Viral markers should be identifiable in neoplastic cells; (7) Antibody titers against the specific viruses should be elevated in victims of cervical neoplasia relative to controls; (8) Prospective studies of women with viral infections should demonstrate an enhanced risk for the development of cervical neoplasia; and (9) Protection from infection should reduce the risk of neoplastic change. The roles of other factors such as smoking⁴ and oral contraceptives⁵ and the possible involvement of other viruses⁶ are not considered.

HSV Type 2 in Cervical Neoplasia

Herpes simplex virus has been linked with cervical carcinoma since evidence of the association of genital HSV and an increased incidence of cervical neoplasia was published.¹ The epidemiology of cervical neoplasia and HSV infections are sim-

ilar. Epidemiological studies of patients with cervical cancer^{7, 8} and HSV^{7, 9} both show that the highest risk factors are multiple sexual partners and early coitus. It is particularly striking that women married to men who were previously married to women with cervical cancer have an increased risk for the development of cervical carcinoma themselves.⁷ The independent significance of multiple partners vs early coitus is not resolved. Other sexually transmitted diseases may also exhibit these epidemiologic features. Other risk factors including marital status, age at first marriage, low socioeconomic status, and history of venereal disease¹⁰ are shared by patients with both cervical neoplasia and HSV infections.

HSV infections in patients with cervical neoplasia antedate the onset of cancer. Although large scale prospective studies are lacking, the modal age for HSV infections is 5-10 years younger than that for cervical dysplasia or cervical intraepithelial neoplasia (CIN), and more than ten years younger than that for cervical carcinoma.^{11, 12}

HSV infections of the female genitalia commonly involve the cervix as well as the vulva and perineum.^{1, 13, 14} In fact, cervical cultures are routinely performed for asymptomatic patients with a history of herpes. Typical herpetic lesions of the cervix are commonly reported, and they are often noted at the squamocolumnar junction.¹⁵ HSV selectively infects cervical squamous epithelial cells,¹⁶ the site of the majority of cervical neoplasms.¹⁷

Two strains of HSV are distinguishable immunologically, genetically, and — most important — biologically.^{14, 18} Eighty to ninety per cent of HSV isolations from genital infections are of the type 2 virus, while the converse is true for HSV 1 and orofacial lesions.¹⁹ The majority of the seroepidemiologic studies that demonstrate an association of HSV 2 with cervical cancer have considered antigenic differences^{12, 19} among the viral strains. Although differences are reported, there is no conclusive evidence that cervical neoplasia is associated with particular subtypes of HSV 2.¹⁹

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The oncogenic capabilities of the herpes viruses have been repeatedly demonstrated.^{19, 20} The etiologic role of herpes viruses in certain animal cancers is well established, particularly in Marek's disease of fowl.²¹ Protection against viral infection provides protection against this cancer in this species.²² The causal role of Epstein-Barr Virus (EBV) in the development of nasopharyngeal carcinoma and African Burkitt's lymphoma is strongly implied; however the possibility that virus infected cells are susceptible targets for the actual carcinogen cannot be excluded.²³ Studies of cell transformation in culture demonstrates the ability of most herpes viruses including HSV 1 and 2 to transform cell lines.^{19, 24} These cell lines are often oncogenic in experimental animals.²³ Two separate fragments of the HSV 2 genome are capable of the *in vitro* transformation of cells.^{19, 24}

HSV is oncogenic in experimental animals. Although active virus infections are frequently lethal in experimental animals, inactivated virus applied to the mouse cervix causes a 35-60% incidence of cervical cancer.²⁵ Adenocarcinoma was more frequent than squamous cell carcinoma. Non-genital inoculation of HSV in newborn hamsters also initiates tumors.²⁶

The detection of HSV in neoplasms has been variably successful. The morphological identification of viral particles in cervical cancers is reported, but this is not indicative of a causal role for HSV. Various viral proteins and nucleic acid sequences have been identified in neoplastic cervical cells.^{13, 19, 23, 24, 27} Thymidine kinase, an early viral antigen (Ag-4), membrane glycoproteins (gA and gB), a viral protein VP-143, and DNA binding proteins (ICSP-11/12 and ICSP-34/35) have all been identified in neoplastic cervical cells. However, the heterogeneity of antibodies and cells studied, as well as the variability in antigens detected, makes interpretation difficult. Nonetheless, these phenomena are definite markers of HSV expression.¹⁸

In spite of the identification of viral protein, nucleic acid hybridization analysis of cervical neoplastic cells often fails to demonstrate the presence of HSV viral DNA.^{27, 28} Unfortunately, the sensitivity of reported studies does not exclude the presence of short DNA sequences (less than 10% of the genome). *In situ* hybridization studies to detect viral RNA sequences have detected HSV specific RNA in 35-67% of the tumors analyzed.^{29, 39} Although possibly related to nonspecific binding of probes, these results suggest that HSV is frequently integrated into the genome of neoplastic cervical cells.

Seroepidemiologic studies consistently show a higher prevalence of HSV 2 antibodies, and higher titers of these antibodies in women with cervical neoplasia as compared to controls.^{12, 31} Although many early studies lacked matched controls and others utilized antigens that were not strain specific, more recent studies with two HSV specific antigens (Ag-4 and HSV-TAA) have demonstrated a particularly high prevalence in the sera from patients with cervical neoplasia.^{32, 33} Larger studies of these more specific antigens should more accurately define the association of a previous HSV infection and the later development of cervical neoplasia.

Most of the studies of HSV infection and cervical neoplasia are retrospective in design, but one prospective study demonstrated a significantly higher frequency of cervical cancer in women with a clinical diagnosis of HSV infection compared to controls.³⁵ A second prospective study, also identifying HSV infection as a risk factor for the development of cervical neoplasia, was recently reported.³⁶

The prevention of cancer by the prevention of HSV infection is a powerful motivation for assigning an etiologic role in carcinogenesis to this infectious agent. Human study of this possibility is not reported, but the immunization of mice with HSV 2 preparations prevents the development of cervical carcinoma following treatment with inactivated HSV 2.³⁷ Presumably the active prevention of human infection, perhaps by immunization, would also decrease the occurrence of cervical carcinoma.

HPV in Cervical Neoplasia

The causal association of genital warts with cervical carcinoma was first proposed in 1974,² although the sexual transmission of genital warts was demonstrated 20 years earlier.³⁸ In 1977 two independent groups^{39, 40} described distinctive cervical epithelial changes in patients with HPV infections. The reported abnormalities were distinct from condyloma acuminata. Characteristically these lesions demonstrate koilocytosis and cytologic atypia, but without the verrucous exophytic contour of condyloma. Clinically they are often described as flat condyloma or endophytic condyloma. These lesions are associated with a high incidence of dysplasia, carcinoma *in situ* (CIS), and even invasive carcinoma.^{41, 42}

Genital warts (condyloma acuminata) are a venereal disease. Epidemiologic studies of HPV infected patients demonstrate that they are often sexually promiscuous, with multiple partners, poor sexual hygiene, and an earlier age of first inter-

course than controls.⁴³ These epidemiological factors are similar to those reported for HSV 2 and cervical neoplasia.

The agent of onset HPV infections parallels the occurrence of genital herpes and gonorrhea.⁴⁴ The peak prevalence is at age 23 years, which is approximately ten years younger than the onset of CIN.^{45, 46} It has been suggested, but not established, that HPV infections might accelerate the development of CIN.^{45, 46} The increasing rates of both HPV infections⁴⁷ and CIN¹⁷ in younger age groups in recent years further support this association. These epidemiologic studies strongly associate prior HPV infections and the subsequent development of cervical neoplasia.

Condylomas arising from an HPV infection are typically seen on the vulva,⁴⁸ although other sites are also frequently infected. The identification of flat and endophytic cervical condylomas^{39, 40} and their recognition by colposcopy has demonstrated that cervical infection by HPV is found in 2% of unselected patients.^{49, 50} Lesions often develop at the squamocolumnar junction, the site of neoplastic transformation.^{51, 52}

Thirty-five subtypes of HPV have been described, and four (types 16, 18, 31 and 35) are associated with flat neoplastic lesions of the cervix.⁵³ Types 6, 10 and 11 are associated with benign papillary genital lesions,⁵⁴ and types 5 and 8 are associated with neoplastic lesions in sun-exposed areas of the skin.^{55, 56} The remaining types are known to cause only benign skin lesions.

The Shope papilloma virus induces squamous cell carcinomas in rabbits^{57, 58} and the bovine papilloma virus causes esophageal papillomas and their malignant transformation in cattle.⁵⁹ In humans, HPV transforms epidermodysplasia verruciformis to squamous cell carcinoma,^{60, 61} but there is little direct evidence of the mechanisms involved. Complete definition of this mechanism will be most important to achieve an understanding of the process of carcinogenesis.

The identification of HPV in neoplastic cells became possible when viral DNA was cloned and subsequently sequenced.⁶²⁻⁶⁴ Molecular probes were then developed to identify HPV DNA in neoplastic cells. This technology has demonstrated HPV subtypes 16 and 18 in invasive squamous cervical carcinomas of the cervix and in Bowenoid papulosis of the penis.^{52, 53} The development of specific antibodies to nondenatured structural virion proteins allows the HPV subtypes to be identified histologically by immunofluorescence or immunoperoxidase tech-

niques,⁶⁵⁻⁶⁸ which may soon have implications for clinical diagnosis of HPV infections.

Seroepidemiologic studies of HPV are not reported, so that the predicted higher frequency of infection in women with cervical neoplasia is not yet confirmed.

Reported prospective studies indicate that cervical HPV lesions behave similarly to classical CIN lesions; *i.e.* they may regress, persist, or progress to more dysplastic forms of CIN or to invasive carcinoma.⁶⁹⁻⁷¹ One two-year prospective study of 343 women with cervical HPV lesions demonstrated that 25% regressed, 61% persisted, and 19% progressed to more severe disease necessitating conization.⁷² These studies suggest that CIN initiated by HPV behaves similarly to classical CIN, but the disease manifests in patients who are ten years younger.

There has been no demonstration of the protective effect of immunization for HPV on the development of cervical neoplasia.

Viral Etiology for Cervical Neoplasia

Present evidence indicates that both HSV and HPV are involved in the development of cervical neoplasia. The lack of consistent evidence for the persistence of HSV in neoplastic cells is consistent with the theory²⁴ that HSV acts as an initiator for cervical neoplasia. This would explain the subsequent loss of most of the HSV genome from transformed cells. In contrast the HPV genome apparently integrates into the genome of the neoplastic cell, and thus may be important as a promoter of neoplastic change.

Synergistic action of cocarcinogens, promoters, and/or initiators is well established for other neoplasms. In the transformation of rabbit papillomas, environmental carcinogens act as cocarcinogens^{57, 58}; in the induction of bovine esophageal carcinomas, bracken appears to act as a promoter⁵⁹; and in the transformation of epidermodysplasia verruciformis lesions, sunlight acts as a cocarcinogen.^{61, 69} HSV and HPV may act in a similar manner in the development of cervical neoplasia.

Activation of a cellular protooncogene or of a viral oncogene provides a possible mode of action for HSV in this process. The activation of the c-myc oncogene during the development of Burkitt's lymphoma and the role of the EB virus in this process may provide a similar example.

The HPV genome is actively integrated into the host cell genome.^{51, 64} This is associated with a 3-30 fold amplification of c-myc and/or c-Ha-ras on-

(Continued on page 130)

Foreign Bodies in the Upper GI Tract

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FOREIGN BODY INGESTION is a common problem in the clinical practice of gastroenterology and gastrointestinal endoscopy with an estimated incidence of about 120/10⁶ population. It may result in significant morbidity, and it causes approximately 1,500 deaths in the United States each year.¹

Ingested gastrointestinal foreign bodies may be managed by observation, endoscopy and/or surgical intervention, and the management represents a challenge even to the most experienced endoscopist. Reported here is the case of a patient who ingested a large piece of chicken meat which became impacted in the upper part of the esophagus and was successfully removed with fiberoptic endoscopy, followed by esophageal dilatation which eliminated the patient's symptoms.

In 1937, Chavalier Jackson published a classic monograph on the management of foreign bodies of the upper airways and esophagus at a time when only the rigid endoscope was available.² In 1945, Richardson reported the use of papain in successfully treating meat obstruction of the esophagus.³ Bigler, in 1966, reported the use of the Foley catheter to extract blunt radiopaque foreign bodies from the esophagus.⁴ Morrissey's 1972 review of fiberoptic endoscopy presents only one case of foreign body removal.⁵ Technical improvement in the flexible fiberoptic endoscope and its accessories has dramatically changed the way foreign bodies in the upper gastrointestinal tract are evaluated and removed. This article is designed to update the diagnosis and management of foreign bodies in the upper gastrointestinal tract.

Case Report

A 38-year-old white male in good health presented in the emergency room with complaints of sudden onset of dysphagia after eating chicken. He complained that food had been sticking in the upper part of his chest for the past two days. The patient tried to dislodge the food by vomiting and forcing it down with fingers into the esophagus as he had

done in the past. He also ate more chicken in an attempt to dislodge the impacted food. The patient gave a history of similar episodes of food impaction in the upper part of the chest intermittently for the past ten years, but he had always managed to dislodge it with various manipulations.

The patient presented in no apparent respiratory distress and without cyanosis or dyspnea and without excessive salivation. His temperature was 32C, blood pressure 140/90 mmHg, pulse 60 and regular, and respiration rate 16. Results of physical and laboratory examinations were unremarkable, and chest x-ray was normal. The patient was prepared for endoscopy with the usual sedation, and 1 mg glucagon was administered intravenously, but his symptoms persisted. An Olympus fiberoptic panendoscope was passed through the oropharynx under direct vision, and a soft meat bolus impacted in the upper part of the esophagus was revealed. An attempt to dislodge the meat with a biopsy forcep was unsuccessful. A polyp retriever was then passed through the endoscope and a portion of the meat was grasped; the endoscope, polyp retriever, and the fragments of meat held in it were withdrawn simultaneously.

The relubricated endoscope was then reinserted and the procedure was repeated, but it was impossible to dislodge or remove the remainder of the impacted meat. By gentle manipulation, the flexible fiberoptic endoscope was passed beyond the obstructing meat and into the stomach. The instrument was pulled back proximal to the meat which was then gently pushed into the stomach with the endoscope. Further evaluation of the patient with a barium swallow and upper gastrointestinal series revealed a small sliding hiatal hernia with moderate gastroesophageal reflux. Repeat panendoscopy two days later confirmed a small hiatal hernia with reflux esophagitis grade 1 to grade 2 degree. No lesion was found in the esophagus, and no significant reaction or edema from the foreign body was noted. Esophageal dilatation was accomplished with Maloney dilators #44, #46, and #50 French, which were passed with ease and resolved the patient's symptoms. Esophageal manometry was recommended, if symptoms persisted or recurred, to rule

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TABLE I
TYPES OF FOREIGN BODIES

Bones:	Buttons
Fish	Spoons
Chicken	Razor blades
Pork	Spoon handles
Duck or Goose	Tacks
Beef	Nut Screws
Coins	Bottle caps
Dentures	Thermometers
Fruit seeds	Toothbrushes
Glass	Automobile keys
Toothpicks	Chains
Wire	Bed Springs
Pins (safety and drawing)	Scissors
Plastic toy	Miscellaneous

out hypertensive upper esophageal sphincter. To date, the patient has remained asymptomatic.

Types of Foreign Bodies

There are two types of foreign bodies — true foreign bodies and food related foreign bodies. True foreign body patients generally are under 40 years of age; patients with food related foreign bodies tend to be over 60 years of age. True foreign body patients often have psychiatric disorders such as suicidal tendencies or alcohol abuse, but the food related group usually has a history of esophageal disease.

Table I shows various types of foreign bodies ingested by patients. Foreign bodies that most commonly cause perforation are toothpicks, toothbrushes, paper clips, nuts, bolts, and chicken bones.

Pathophysiology

There are several areas of physiological narrowing in the esophagus. Two-thirds to three-fourths of all objects obstruct the upper third of the esophagus. The lumen of the esophagus is normally reduced at several points by normal anatomical structures. The cricopharyngeus muscle creates the area of greatest narrowing at about 15 cm from the incisor teeth, the aortic arch narrows the lumen at 23 cm, left main stem bronchus at 27 cm, and the lower esophageal sphincter at 39-43 cm. Other physiologically narrowed areas of the gastrointestinal tract are the pylorus, ileocecal valve, and anus.

Pathological states that predispose to foreign body retention are esophageal stricture due to gastroesophageal reflux disease, rings and webs, esophageal tumor, pyloric obstruction secondary to peptic ulcer disease, duodenal diaphragm, hernia, and motility disorders.

Clinical Presentation

History is important in the diagnosis of foreign body ingestion, but it may be impossible to obtain from children and psychotic or intoxicated patients. The presenting symptomatology usually includes odynophagia and dysphagia of sudden onset. Other helpful clues are regurgitation, sialorrhea, epigastric pain, vomiting, and bleeding. A history of gagging and choking during meals is a common symptom. In children, refusal to eat food, increased salivation, pain or discomfort with swallowing, and vomiting are the most common symptoms in order of frequency. In some cases there may be no history of symptoms other than failure to thrive. A classic example is a child who failed to thrive and was found to have a coin impacted in the esophagus.

Diagnostic Considerations

The diagnosis of foreign body ingestion depends upon the following triad: clinical history, x-ray appearances, and fiberoptic endoscopy. Diagnosis can be difficult in children and in psychotic patients. A history of ingestion may be absent or be overlooked because the event occurred long before the patient seeks medical help. Currently accepted forms of evaluation include radiographic studies and fiberoptic endoscopy. Plain films in the frontal and sagittal planes should be the initial approach in the diagnosis of such patients. Flat, thin objects such as coins orient themselves with their greatest diameter in the frontal plane of the esophagus and in the sagittal plane of the trachea. Many foreign bodies such as toothpicks, small fish or chicken bones, and glass or plastic objects are not radiopaque. Xeroradiography may be considered to detect subtle changes such as free air in the soft tissue that would indicate perforation. A plain film should always be repeated just prior to any planned intervention for foreign body removal because the foreign body may have migrated since the previous study. If the plain film is unrewarding, contrast studies with small amounts of barium may be considered, but aspiration of the barium and coating of the foreign body must be considered. Gastrografin ingestion is the preferred study in some cases of perforation. However, if aspirated, it may cause severe chemical pneumonitis.

Therapeutic Considerations

Correct decision making in the management of ingested foreign bodies is at times difficult, but *do no harm* should be the main concern in the approach to these patients. Psychotic, suicidal, and schizo-

phrenic patients are the most difficult to manage. Therapeutically, many forms of treatment have been employed including observation, endoscopic removal, and surgical retrieval of foreign objects. Objects impacted in the hypopharynx and the esophagus should be removed as soon as possible because impaction causes trauma that may result in swelling, which compounds the problem. The only exceptions are round objects and food in the distal esophagus which may pass spontaneously. If a patient is doing well, one may wait for as long as 12 hours, but should never push a bolus or foreign body blindly forward into the esophagus. Most foreign body ingestion limited to the esophagus can be managed endoscopically, but the management of the gastric foreign body is different from that for the esophageal foreign body.

Acute Esophageal Food Impaction

An initial approach in the management of these patients could be administration of a gas forming agent such as solution of tartaric acid followed immediately by soda bicarbonate. If this fails, the patient may be given intravenous glucagon, 0.5-2.0 mg, followed by a drink of water with the patient upright. Although the success rate is low, the above procedures are safe and worthwhile.

Most foreign body ingestion of the esophagus can be managed endoscopically. Flexible fiberoptic endoscopic procedure with various forceps, snares, baskets, or other appropriate instruments should be used for the removal of the foreign body if other measures fail. A rehearsal of the procedure should be carried out by grasping a similar object with various instruments prior to endoscopic removal. Pointed and sharp objects require additional precautions to prevent injury to the esophageal and pharyngeal mucosa. Larger and more pointed objects such as safety pins will require a flexible overtube into which the object is drawn.

Foreign Bodies in the Stomach

Most objects that have passed into the stomach will ultimately pass through the gastrointestinal tract, usually within five days. The patient may be observed for ten days to two weeks provided s/he is doing well and the object is non-toxic. In children, objects up to 2 cm in diameter and 5 cm in length may pass. In adults, objects as long as 13 cm may pass. Long and sharp objects have a higher incidence of perforation and are best removed endoscopically.

Perforation may occur distal to the stomach, and

common sites reported are appendix, Meckel's diverticulum, ileum, cecum, and various levels of the colon. Colonoscopy appears to be an acceptable mode of recovering foreign bodies when they have passed beyond the ileocecal valve. After successful removal of the foreign body, the patient should be reevaluated for underlying disease that may have caused the obstruction, especially in the esophagus.

Surgical Retrieval

The incidence of complications involving foreign body ingestion is related to the size, type, and number of objects ingested. Surgical intervention should be a last resort in these patients. Indications for surgery include large size foreign bodies and a failure to show radiographic signs of passage (*i.e.* large and long objects that fail to clear the stomach within three to five days), acute abdomen without frank peritonitis, peritonitis, gastrointestinal bleeding, and obstruction and perforation of the esophagus secondary to endoscopy or due to foreign body impaction.

Conclusion

Ingested foreign bodies may be managed by observation, endoscopy, and/or surgical intervention. Although somewhat controversial, papain should not be used for food related foreign bodies in the distal esophagus because of potentially lethal complications related to aspiration of the enzyme from the obstructed esophagus resulting in chemical pneumonitis. A flexible overtube has many uses in endoscopy, but is an indispensable instrument for the removal of foreign bodies from the esophagus. Removal of foreign bodies from the upper esophageal sphincter presents additional challenges to the endoscopist because the foreign body in the sphincter is held tightly by the muscles which are normally tightly contracted as was the case in our reported patient. The overtube is helpful in such situations because it can act as a retractor.

In our patient a soft meat bolus was impacted in the upper esophagus. Initial management of sedation and intravenous glucagon was unsuccessful. It also was not possible to dislodge or remove the soft meat bolus with biopsy forceps or a polyp retriever, but with gentle manipulation the fibero-endoscope was passed beyond the obstructing meat bolus and into the stomach. The instrument was pulled back proximal to the impacted meat and the bolus gently pushed into the stomach. The flexible fiberoptic endoscope may have dilated the upper esophageal

(Continued on page 133)

Post-Splenectomy Sepsis

MARY L. BARNES; KAY L. SAVING, M.D., and TRIBHAWAN S. VATS, M.D.,
Kansas City, Kansas

SPLENECTOMY is considered a technically simple surgical procedure. However, its performance for any purpose has been shown to have long-term risks, including the major one of sepsis. The syndrome of post-splenectomy sepsis (PSS) is characterized by a rapid onset of fever and chills, malaise, nausea and vomiting, headache, and mental confusion. These symptoms can progress to seizures or coma, shock and DIC, along with electrolyte and acid-base disturbances. The septic episode frequently ends in death within a few hours of onset.¹⁻³

The increased incidence of sepsis in the asplenic patient has helped stimulate a growing body of knowledge regarding the role of the spleen in the human immune system. Leonard *et al* observed that the splenectomized patient with sepsis may have more than 10^6 organisms per ml of blood, while a septic patient with an intact spleen normally has only 10^3 organisms per ml.⁴ These increased numbers of organisms in the splenectomized patient may be a result of decreased opsonization of encapsulated bacteria (pneumococcus and *H. influenza*), with resultant decreased phagocytosis. Other immune defects noted in the splenectomized patient include reduced alternative complement pathway activity, reduced levels of serum IgM, and an altered response to injected antigens, with a lack of typical progression from IgM production to IgG.^{1, 3, 4} Some studies indicate that a normal spleen may act to "trap" antigens, enabling better antibody formation and function by aiding in cell-to-antigen and cell-to-cell interactions. Polymorphonuclear (PMN) phagocytic effectiveness may be decreased in these patients secondary to a deficit of tuftsin, a product of the spleen that binds to PMNs and doubles their ingestion capacity.⁵ Research in this area is still incomplete, and it is not known why some asplenic patients — especially those splenectomized following trauma — have normal tuftsin levels.

Overall incidence of and mortality from PSS was demonstrated in Singer's review of 2975 post-splenectomy children, which revealed that 4.25% developed sepsis, and 2.5% overall died from sepsis.⁶

The frequency of sepsis is 60 times greater in splenectomized vs normal children,¹ and the risk of dying from that sepsis is 50 times greater than that of the general population.⁵

The indication for splenectomy also influences the frequency of sepsis. Splenectomy following blunt abdominal trauma appears to have the least frequency of sepsis. A Swedish review of 413 cases from 1968-1977 of splenectomy after blunt trauma in children under 15 years of age, showed morbidity due to sepsis to be 2.4%, with a 1.2% mortality rate. These figures are much lower than those quoted for septic episodes in children undergoing splenectomy for all reasons. The incidence of post-splenectomy sepsis is also lower in those patients who require splenectomy for treatment of certain hematologic disorders, such as ITP or hereditary spherocytosis. The risk of post-splenectomy sepsis is greatest in patients who are already immunocompromised, such as those with Wiscott-Aldrich syndrome. Patients with intermediate risk factors are those with splenectomy during staging of Hodgkin's disease, autosplenectomy secondary to sickle cell disease, or congenital asplenia.^{2, 7}

One of the most important determinants of frequency of post-splenectomy sepsis is patient age at the time of splenectomy. The greatest risk of post-splenectomy sepsis occurs in infants less than 12 months of age, although young children are still at a relatively higher risk up to age 5 years.

The risk of PSS also varies as a function of time post-splenectomy. In one study, *overwhelming* sepsis was not very common, but the rate of serious infections that required hospitalization was 33% in the first ten years post-splenectomy.⁸ The patient risk during the first year after surgery was 17%, with the risk during the remaining nine years gradually dropping to only 1.6%.⁸ In children, 80% of septic episodes occur during the first two years after surgery.³ A study by Posey and Marks of 55 children showed the interval between surgery and sepsis to be somewhere between eight months and six years, with the average being 3.7 years.² In adults, the average interval to sepsis is 5.8 years, with a range of seven months to 25 years.¹ Even though the risk

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of post-splenectomy infections decreases with time, the severity of infectious episodes continues to be the same.

The most common etiologic agent of PSS is *Streptococcus pneumoniae*, accounting for 55% of the septic episodes overall.³ *Neisseria meningitidis*, *E. coli*, and *H. influenzae* account for another 25%, with the remainder being caused by a variety of organisms, including *Salmonella* species, *Streptococcus hemolytica*, and *Staphylococcus pyogenes*.

In light of the frequency of overwhelming post-splenectomy sepsis reported in the literature (especially in pediatric patients), many surgeons are adopting a more conservative nonoperative approach to splenic injury in the hemodynamically stable trauma patient.⁵ Trauma surgeons have observed that few injured spleens (15-30%) are bleeding at the time of initial laparotomy.⁴ Attempts to salvage the spleen by only partial removal or by using omentum as a splenic wrap or patch to the injured area have met with some success.¹ Splenosis, the intra-abdominal implantation of splenic pulp cells from damaged spleen, has been suggested to occur in up to one-half of children splenectomized post-trauma.⁹ Some human and animal studies indicate that splenosis does not appear to preserve splenic immune function unless a "critical mass" of splenic tissue has been preserved with close ties to the portal vasculature.⁴ Other studies have refuted the value of splenosis and the "critical mass" concept.

In spite of the risk of PSS, total splenectomy may be unavoidable in a number of instances, including trauma, hypersplenism, and various hematologic disorders such as spherocytosis. In an attempt to prevent sepsis from *S. pneumoniae* — the most common causative organism of PSS — the polyvalent pneumococcal vaccine was developed.¹⁰ Early studies of pneumococcal vaccine in children showed a definite decrease in number of septic episodes secondary to *S. pneumoniae* in asplenic children receiving the vaccine when compared with those who did not. Since children given the pneumococcal vaccine just prior to or at the time of surgery often do not demonstrate the two-fold rise in antibody titer needed to gain a protective effect, the vaccine should be given at least several weeks prior to the splenectomy, if possible. Vaccination with the polyvalent vaccine still does not guarantee protection against all pneumococcal infections. Cases of overwhelming sepsis in patients vaccinated either pre- or post-splenectomy, from both vaccine and non-vaccine strains, have been reported.¹⁰ There also

continues to be debate as to duration of protection provided by the vaccine.⁹ Because children under 2 years of age exhibit an inadequate immunologic response to the vaccine, it is presently recommended only for patients over 2 years of age.¹⁰

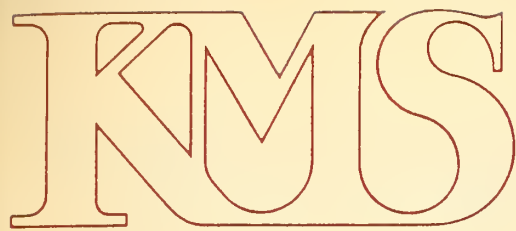
Even with the pneumococcal vaccine, asplenic patients are still at increased risk for sepsis, and therefore, should be treated urgently for any signs of illness. In an attempt to reduce this risk, many researchers recommend daily prophylactic oral penicillin (or ampicillin, for *H. influenzae* in patients less than 4 years of age).^{1, 9, 10} The recent multicenter controlled clinical trial in patients with sickle cell disease showing a decrease in septic episodes in patients taking prophylactic penicillin, may give further support to penicillin prophylaxis in all splenectomized patients. Perhaps the problem of non-compliance with daily oral medications in these patients could be overcome by intensive patient/parental counseling at initiation and followup visits, or by monthly parenteral penicillin.

Since the first description of post-splenectomy sepsis by King and Schumacher in 1952, much has been learned about the immune function of the spleen. However, morbidity and mortality from post-splenectomy sepsis still exists, even with the protective effects of pneumococcal vaccine and prophylactic penicillin. Therefore, splenectomy for any reason, especially in a small child, should not be undertaken lightly. The physician who cares for asplenic patients for any cause should continue to thoroughly counsel them on the importance of prophylactic antibiotics and quick medical referral in cases of suspected infection. Research should be encouraged in methods of splenic salvage and basic splenic function, in an attempt to further reduce the incidence of this potentially fatal entity.

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(Continued on page 124)



KANSAS MEDICAL SOCIETY

Newsletter

1300 Topeka Ave. • Topeka, Kansas 66612 • (913) 235-2383

APRIL 1987

LEGISLATIVE UPDATE

The legislature has reached its first adjournment point, with several major issues yet unresolved. The legislature reconvenes on April 29th for a four-day wrap-up session, with final adjournment expected Saturday, May 2. Although legislative action is not yet final on some of these issues, the following is a brief highlight on some legislation of interest:

Optometric Scope of Practice. SB 113, the bill which expands optometrists' scope of practice has passed both houses of the legislature. The bill prohibits the treatment of glaucoma by optometrists, and limits the use of steroids to a 14 day supply, but also allows optometrists to remove superficial foreign bodies from the cornea and conjunctiva. KMS opposed the bill, even though we've succeeded in limiting it somewhat with the above amendments.

Healing Arts Board Issues. SB 34 establishes a full-time executive director of the Board, in an attempt to consolidate the administrative responsibilities into one position. The bill, which becomes effective January 1, 1988, has passed both houses and is expected to be signed by the Governor. SB 36 is a KMS-supported bill which creates an "exempt" license to allow certain retired physicians to maintain their active license to practice medicine, but be exempted from the mandatory malpractice insurance and continuing medical education requirements. The bill has passed both houses of the legislature and the Governor is expected to sign it. The bill was intended to help physicians who wish to maintain their licenses in order to do certain volunteer work, administrative duties, and other non-patient care activities. KMS is pressing the Board of Healing Arts to implement the provisions immediately so that physicians can take advantage of the change in law during this year's licensure renewal process. However, it is not yet known whether the Board will be able to act quickly enough to implement the bill by the time renewals go out in May.

Smoking in Public Places. HB 2412, introduced at KMS request has now passed both houses and the Governor is expected to sign it. The bill would require that no-smoking areas be designated in every public place, including retail stores, businesses, physicians' offices, and other health care institutions. The bill does not prohibit smoking in public places--it just requires that no-smoking areas be designated and appropriately marked.

Physician Assistants: Prescribing of Drugs. Substitute for SB 35 addresses a part of the Healing Arts Act that has to do with PA prescribing. The bill has passed both houses and the

In This Issue...

- Legislative update
- AIDS Task Force/Guidelines
- Medicare assignment--mandatory?
- Assistant surgery denied
- Ethics of impairment
- Gov's Conference on Aging: Topeka, May 21
- Physician DRGs?
- Help wanted: KDHE Secretary
- Conference: Performance-Based Reappointment & Dealing With Impaired Professional: Salina, June 20

Governor is expected sign it. KMS succeeded in amending the bill by adding language that would require the Board of Healing Arts to adopt rules and regulations specifically limiting and regulating the prescribing of drugs by PAs in various practice settings. The bill now provides that PAs may not prescribe independently, but may transmit prescription orders according to written protocols adopted by the supervising physician.

A more detailed explanation of all legislation of medical interest will appear in the next Legislative Bulletin which all KMS members should be receiving shortly. In the meantime, if you have questions about the above bills or other legislation, please call the KMS office at 1-800-332-0156.

AIDS TASK FORCE

Lt. Governor Jack Walker, M.D., in his capacity as Acting Secretary of Health & Environment, has named his appointees to the 15-member task force to study AIDS in Kansas. KMS members included, in addition to Walker, are William J. Reals, M.D., Wichita, Chairman; Donald W. Hatton, M.D., Lawrence; and Donna E. Sweet, M.D., Wichita.

AIDS TEST GUIDELINES

The CDC has issued comprehensive guidelines to determine who should be tested for AIDS. The guidelines are available on request from the KMS office.

MARYLAND DEFEATS MANDATORY MEDICARE ASSIGNMENT . . .

The Maryland House Environmental Matters Committee defeated a mandated Medicare assignment bill with only one favorable vote. In their efforts to defeat the bill, physicians representing all specialties emphasized the problems associated with the administration of Medicare. It was noted that 80% of physicians fully accept Medicare assignment on a case by case basis.

BUT MASSACHUSETTS LOSES APPEAL . . .

In Massachusetts, however, the state's law requiring mandatory acceptance of Medicare assignment by physicians as a condition of licensure was upheld by the First Circuit Court of Appeals. The AMA announced that it will appeal the decision to the U.S. Supreme Court.

AND OPHTHALMOLOGISTS LOSE CASE AGAINST HHS

Ophthalmological societies in New York and California have been denied help from the federal courts to prevent the Department of Health & Human Services from enforcing new regulations that would restrict the use of assistant surgeons in cataract operations for Medicare patients. Attorneys for the societies plan to appeal the decision that denied a preliminary injunction and dismissed the lawsuit challenging the constitutionality of the new Medicare provisions applicable only to ophthalmologists.

ETHICS OF IMPAIRMENT

The AMA Council on Ethical and Judicial Affairs has issued the following statement:

Physician Impairment: In order to protect patients and the public, physicians have the responsibility of reporting to the appropriate body credible evidence of a colleague's impairment that affects competence. Such impairment may result from abuse of drugs or alcohol, or from mental or physical illness. All physicians have an obligation to urge impaired colleagues to seek treatment.

Substance Abuse: It is unethical for a physician to practice medicine while under the influence of a controlled substance, alcohol, or other chemical agents that impair her/his ability to practice medicine.

Sexual Misconduct in the Practice of Medicine: Sexual misconduct in the practice of medicine violates the trust the patient reposes in the physician and is unethical.

GOVERNOR'S CONFERENCE ON AGING

The 12th Annual Governor's Conference on Aging will convene in Topeka, May 20-22, on the Washburn University campus. "LEADING THE WAY: Generations of Wisdom and Innovation," is the theme and focus of the conference. Structured for older Kansans and providers of services to the aging, the conference will offer an opportunity for participants to discuss and share ideas on current issues involving the elderly. It will feature workshops, speakers, exhibits, entertainment, and other events. Kansas physicians are strongly encouraged to participate as attendees. Workshop leaders will include the following KMS members, who will present on May 21, in the afternoon:

Jimmie A. Gleason, M.D. - Quality Health Care
Marcia M. Hostetter, M.D. - Osteoporosis
Donald H. Jackson, Jr., M.D. - Heart Disease
Paul H. Kindling, M.D. - Laser Therapy

Registration Info: KMS, 1-800-332-0156 (235-2383);
Washburn University: 913-295-6619; or
Kansas Department on Aging: 1-800-432-3535 (296-4986)

PHYSICIAN DRGs

PHYSICIAN REIMBURSEMENT UNDER DRGs: PROBLEMS & PROSPECTS was developed as the third volume in the AMA's Prospective Pricing System (PPS) informational series. The publication is particularly timely right now, as the Reagan administration is pressing to include Medicare payments for services provided by radiologists, anesthesiologists, and pathologists (RAPs) in the hospital's DRG payment. This booklet focuses on the potential problems that would be experienced under such a reimbursement system. Info: Order Dept., OP-232 AMA, P.O. Box 10946, Chicago IL 60610; 312-280-7168.

AMA and KMS strongly oppose a DRG-based physician payment plan. It would be detrimental to access and quality, and would create unwarranted patient expenses and tremendous economic incentives for withholding care. While DRGs fail to pay for services actually rendered, they may pay for services not performed. The proposal is not responsive to Congressional direction and is premature, since Congress-directed studies of this matter have not yet been concluded.

Concurrent resolutions have been introduced in House and Senate opposing physician DRGs. These are SCR 15 and HCR 30 (Senate and House respectively). KMS has asked the Kansas congressional delegation to sponsor the resolutions, and the following Kansas Representatives have already signed on in support: Glickman, Roberts, and Whittaker.

POSITION AVAILABLE

The position of Secretary of Kansas Department of Health & Environment is a cabinet-level position appointed by the Governor.

Responsibilities

- community & personal health services
- adequate sanitary conditions in public health facilities
- regulation of environmental quality
- implementation of legislative mandates
- establishment of policies consistent with statutory requirements

Qualifications

- ability to administer, at a high level, public health & environmental programs
- manage & set policy concerning complex public health & environmental issues
- ability for strong, innovative administration in legislative, fiscal, program, and policy matters
- broad experience in public administration
- capacity & commitment to serve as a team member
- an advocate for the Governor's programs

The Secretary administers an annual budget of some \$40 million and manages a staff of more than 600 persons. For consideration, submit a letter of application and resume with salary history and professional references by May 15, 1987, to:

Secretary of Administration, State Capitol, Topeka KS 66612-1572

PERFORMANCE-BASED REAPPOINTMENT & DEALING WITH THE IMPAIRED PROFESSIONAL

Sponsors: KMS, KHA and Hospital Services Group
Salina, Kansas Holiday Inn June 20, 1987

Objectives: Kansas recently passed tort reform legislation that requires hospitals to report acts that are below the standard of care, disciplinary actions taken by the Hospital Board of Trustees, and similar practitioner problems. This seminar is designed to help hospital medical staffs to establish a performance based credentialing system and to develop procedures to deal effectively with the impaired practitioner.

TOPICS TO BE DISCUSSED INCLUDE:

- What is performance-based credentialing?
- Where does the needed information come from?
- Who does what?
- Defining and understanding impairment
- Recognition of impaired practice
- Approaching the problem
- Facilities and resources available for rehabilitation of impaired professionals.

There is a \$50 registration fee for KMS members. Make room reservations directly with the hotel.

PERFORMANCE-BASED CREDENTIALING SEMINAR

Name(s) _____

KMS members @ \$50 # _____

Non-members @ \$75 # _____

Mail with your check to Kansas Medical Society, 1300 Topeka, Topeka KS 66612.

Brainstem Auditory Evoked Potentials in Dizziness

I. AHMED, M.D.,* *Kansas City, Missouri*

DIZZINESS is one of the most common symptoms for which a patient seeks medical attention. Patients vary in their description of dizziness, and it can encompass a feeling of rotational sensation of either self or environment, a sense of impending faint, a sense of dysequilibrium, or an ill-defined light headedness.¹ It scarcely should be surprising then that there are multiple etiologies of dizziness. Attention usually focuses on vestibular disorders, but retro-cochlear, brainstem dysfunction, and other medical problems such as cardiac disorders and peripheral neuropathies all contribute to symptoms of dizziness. Initial assessment of the labyrinth may be made by electronystagmogram or audiogram, but a comprehensive evaluation is also recommended.²

Brainstem disorders usually constitute a small percentage of cases of dizziness. However, C. Miller Fischer found that 77% of his patients with vertebro basilar ischemia had dizziness as their presenting complaint.³ In order to evaluate the incidence of brainstem dysfunction, we systematically examined 100 cases of dizziness using not only traditional dizziness laboratory tests, but brainstem evoked potentials as well. Usefulness of brainstem auditory evoked potentials in post-concussion dizziness to delineate brainstem abnormalities has been well described.⁴⁻⁵

Brainstem auditory evoked potentials (BAEP) is an accurate and objective measure of auditory nerve and brainstem auditory pathways.⁶⁻¹⁰ It is the sub-microvolt neural signal recorded following presentation to a patient of the monaural click stimulus by ear phone. Response to the click is recorded and summated by a digital averaging computer. The response that occurs during the first 10 milliseconds following the click consists of a seven-peaked wave form. These peaks are known to represent (1) the response of generators in the region of the auditory nerve; (2) cochle nucleus; (3) superior olivary complex; (4) lateral laminiscus; and (5) inferior colliculus. Peaks 6 and 7 — although thought to be generated in the thalamus and auditory radiations

— have not yet been fully localized. The difference in latency between these peaks is a measure of the conduction time between the generators. Lesions of the brainstem affecting the auditory pathways will result in slowing of these conduction times, and therefore distort the response and prolong the interpeak latencies. Usefulness of BAEP in a wide variety of lesions including multiple sclerosis, brainstem vascular disease, trauma, tumors, differentiation of coma from toxic metabolic etiologies from structural lesions, degenerative disorders and transtentorial herniation, have all been well described.¹¹⁻¹⁹

We studied 100 consecutive patients with non-traumatic dizziness. The results of our findings form the basis of this report.

Methods and Materials

The study population was comprised of 100 consecutive patients with a history of dizziness seen at the Veterans' Administration Hospital Neurology Clinic. Their ages varied from 45-60 years, average age 55 years.

Data compiled for each patient included history, complete physical and neurological examination, neuro-otological examination; laboratory data, BAEP, special medical examination, and neuro-otological studies.

A description of the dizziness was obtained in patients' own words, and included lightheadedness, a swimming feeling in the head, rotational experience, or sense of the loss of balance. Neuro-otological examination included electronystagmography performed on Four Channel Life Tech Instrument. This included examination for gaze, smooth pursuit, positional testing, and Hallpike maneuver as well as caloric testing. Hearing evaluation included air and bone conduction, pure tone-threshold, speech discrimination, and Bekesy audiometry. Medical laboratory tests were performed as necessary.

Brainstem Evoked Potential Measurement

Brainstem evoked potentials were recorded in a quiet room. Subjects lay in a supine position with

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TABLE I MEAN LATENCIES AND STANDARD DEVIATION IN NORMAL CONTROL		
Wave Forms	Latencies	Standard Deviation
Wave I	1.8 msec	0.15 msec
Wave I-II	1.0	0.1
Wave I-III	2.1	0.20
Wave III-V	2.2	0.19

the head supported to reduce muscle noise. No sedation was used. An auditory stimulator delivered negative polarity clicks of 0.1 millisecond duration. Masking noise was presented to the unstimulated ear. All subjects were tested at 10 and 20 clicks per second. Intensity of stimulus was 65 decibel sensation level. Silver chloride cup electrodes were applied with collodion to the vertex and each ear lobule. Resistance of the scalp underneath the electrode was reduced to less than 5,000 ohm in every case. The recording was made between the vertex and ipsilateral ear with contralateral ear used as ground. The amplifier's passband was 100-3000 hz. Responses were averaged with an averager, using a sweep duration of 10 milliseconds. In most instances 2,000 responses were averaged. At least three traces were recorded for each ear and written out by means of an X-Y plotter.

Measurement: All wave forms from I, II, III, IV, and V were identified based on morphology and latencies. Peak latency of a wave was easy to measure when the wave consisted of a sharp rise and fall, but when the wave was broad and flat-topped, latency was not so easy to determine. Latency was determined using Starr and Achor's criteria.²⁰ Amplitude variation was not used as a criterion for abnormality.

Patients and control subjects: Fifty subjects (25 men and 25 women) were chosen from hospital staff, nurses, and friends to serve as a control group. None had a history of hearing defects, dizziness, or neurological illness. *Table I* represents mean latencies and standard deviation in the 50 control subjects. Interwave latencies were used instead of absolute latencies. Latency variation between each ear was calculated for each subject, and did not exceed three standard deviations in any instance.

Criteria of Abnormality: Abnormalities were defined as (1) wave peak latencies that fall beyond 3SD of the control subjects, or (2) failure to record a response. Among the patient group, five with acoustic neuroma showed either prolongation of the

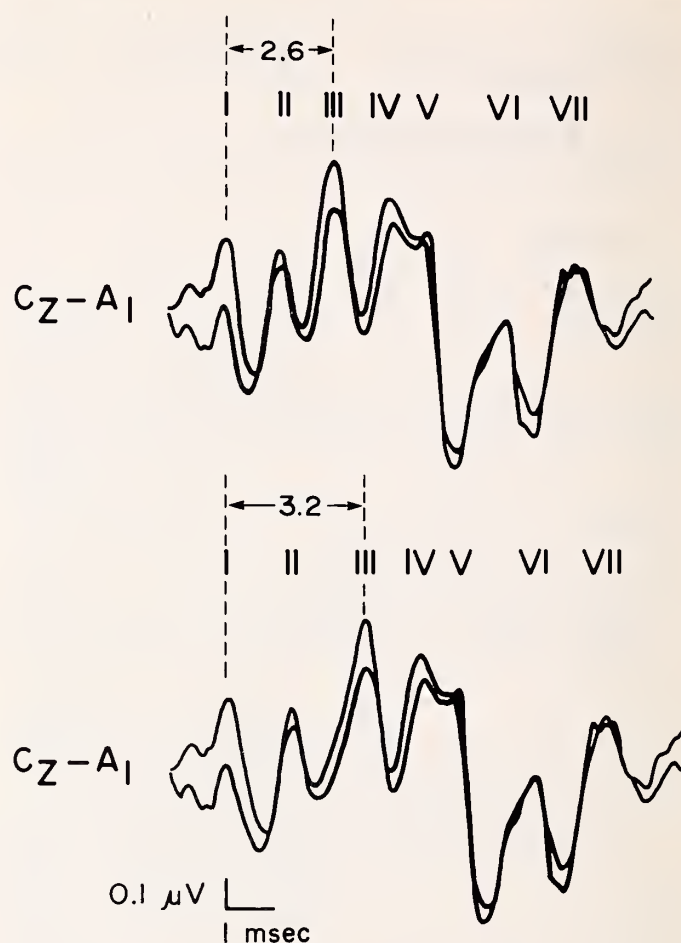


Figure 1. Abnormal interpeak latencies determined by brainstem auditory evoked potentials.

Wave I latency or failure to record a response. In addition, 13 other patients showed abnormality of I-III and III-V interpeak latency beyond 3SD. Nine patients showed abnormality of I-III interpeak latency, and four showed prolongation of III-V interpeak latencies (*Figure 1*).

Results

One hundred consecutive patients were studied. Major etiologies of dizziness are tabulated in *Table II*.

Peripheral Vestibular Dysfunction

Dizziness in 40% of the patients was attributed to peripheral vestibular dysfunction. These patients complained of vertigo with systemic symptoms, and the dizziness was usually positional. Neurological examination did not reveal additional brainstem signs; electronystagmography was most useful in the diagnosis,^{21, 22} and this examination included testing for spontaneous, rotational, coloric, positional, and optokinetic nystagmus. The diagnosis of peripheral vestibular dysfunction was based on clin-

TABLE II
CAUSES OF DIZZINESS IN 100
CONSECUTIVE CASES

Peripheral vestibular disorder	40
Multiple sensory deficits	15
Brainstem disorders	13
Psychiatric disorders	10
Tumor	6
Hyperventilation syndrome	9
Cardiovascular problems	5
Others	2

ical impressions and electronystagmographic findings. Brainstem auditory evoked potentials were normal in each instance. *Table III* lists various etiologies of peripheral vestibular dysfunction encountered in the study.

Multiple Sensory Defects

The entity first described by Drachman *et al*² states that an organism deprived of sensory stimuli — such as visual, auditory, proprioceptive, pressure, and touch — would become disoriented in space, and in human beings it may result in subjective sensations of dizziness. This is commonly seen in older patients who complain of imbalance on standing, walking, or turning. Fifteen percent of our patients were in this category. No abnormalities of brainstem evoked potentials were noted in these cases.

Brainstem Disorders

Thirteen percent of patients were found to have abnormal brainstem evoked potentials with prolonged latencies beyond 3SD. (Most of the abnormalities were confined to the lower brainstem, with abnormal: 1-3 interpeak latencies in 9 of 13 cases.) Typically, these patients have constant feelings of dizziness unrelated to posture with occasional exacerbation of the symptom to the point that they have suffered multiple falls. Neurological examination at that time did not reveal any focal brainstem signs; however, subsequent followup of these patients for the next 18 months revealed that three of these patients developed clear-cut episodes of transient cerebral ischemic attacks during the next three to four months in the vicinity of the vertebrobasilar artery. These attacks were expressed as diplopia, bilateral visual loss, or dysarthria. Two additional cases developed brainstem infarctions — one patient developed lateral medullary syndrome, the other had Millard-Gubler syndrome. Four patients treated with anti-platelet drugs noted a gradual decrease in diz-

TABLE III
VARIOUS ETIOLOGIES OF PERIPHERAL
VESTIBULAR DYSFUNCTION ENCOUNTERED
IN THIS STUDY

<i>Etiologies</i>	<i># of Patients</i>
Acute labyrinthitis	10
Benign positional vertigo	12
Menier's disease	6
Vestibular neuronitis	8
Chronic vestibulopathy	4
Total	40

ziness during the following 9-12 months. The remaining patients were lost to followup.

Tumor

Five patients who complained of recurrent vertiginous episodes and dysequilibrium, as well as hearing impairment, were found to have acoustic neuromas. Brainstem evoked potentials were abnormal in all five cases. Abnormality was confined to delayed latency of Wave I (2 cases) or inability to elicit a response in that ear (3 cases). One additional case is of interest in that this patient with episodes of recurrent vertigo was found to have temporal lobe glioma. Various other etiologies encountered are listed in *Table II*.

Comment

For purposes of this study, dizziness was defined as a disorder of human spatial disorientation. As noted in previous studies, peripheral vestibular disease remains the most common cause of dizziness, accounting for 40% of the total cases. Benign positional vertigo is the most common of the various peripheral vestibular disorders. Such tests as electronystagmography and several modifications of it, including the vestibulo-ocular pursuit tests, provided the most useful documentation.

One important feature of the present study is the use of BAEP in dizzy patients. Since disturbance of physiological activities in the brainstem auditory pathway is indicative of brainstem disease, and the various generators of the wave form have been fairly well recognized and accepted in the literature, we applied them in the evaluation of dizzy patients to determine the incidence as well as to look for causes of these abnormalities. Eighteen responses were categorized as abnormal, based on the criteria of abnormality of latencies or absence of response. We did not use amplitude variation as a criterion since it still has not been well accepted when it occurs

alone without changes in latencies. Of the 18 patients, five were found to have acoustic neuromas. In the remaining 13 patients, clinical complaints were of nonpostural dizziness associated with ataxia, at times severe enough to cause difficulty in walking for some patients. Constitutional symptoms such as vomiting were not prominent. Regular followup for cases that could be documented for the next 18 months (9 of 13), revealed that all developed additional symptoms suggestive of brainstem vascular dysfunction. In four patients, spontaneous cessation in dizziness was noted during the next eight to nine months. This can occur in patients with vascular disease of the brain, and perhaps results from improved collateral circulation. When the abnormal responses were analyzed further, the consistent abnormalities were noted primarily in prolongation of the I-III interpeak latencies (9 of 13 responses) indicating disturbances in the lower brainstem function. Other studies of post-concussion dizziness yielded similar results.⁴⁻⁵

Recently, Janetta *et al*²³ described nine patients with disabling positional vertigo; these patients have constant positional vertigo or dysequilibrium so severe that they are disabled and constantly nauseated. Eight of these nine patients had abnormal brainstem evoked potentials. These changes consist of either latency shift of Wave II or an abnormal amplitude and shape of Wave III. At surgery, primary findings were that of vascular compression of the vestibular nerve intracranially. All patients improved following microvascular decompression of the eighth nerve. In addition, five patients had complete or partial relief from tinnitus. In the present study, none of the patients who had normal evoked potentials reported symptoms similar to those described by Janetta *et al* — that is, the disabling vertigo on position with nausea — but on the other hand, they experienced non-positional dizziness and a feeling of loss of balance with ataxia, but without vertigo and nausea. None of our patients with abnormal evoked responses underwent microvascular decompression.

C. Miller Fischer³ evaluated the symptoms of dizziness and vertigo in cerebrovascular disease. He indicated in his study that dizziness is the cardinal sign of basilar artery insufficiency. The basilar artery and its branches supply blood to eight nerve and vestibular nuclei. Of 112 patients with basilar artery occlusion, 77% had symptoms of dizziness. In 25% of these cases, dizziness was the presenting symptom. In approximately 50% of cases, dizziness was one of the two initial symptoms. In cases where

dizziness was the first symptom, the dizzy attack could occur hours, days, or months before the next neurological sign was added; usually, however, stroke will occur within six weeks. In anterior inferior cerebellar artery syndrome, dizziness occurred in nine of ten cases. It was the unaccompanied first sign in three cases. Similarly, in the lateral medullary syndrome, the majority of the patients complained of dizziness; again in vertebral artery insufficiency and subclavian steal syndrome, dizziness could be the only presenting symptom. Other reports on this subject have revealed similar results.²⁴⁻³⁰ Lynn *et al*¹⁶ described abnormalities of brainstem evoked responses in three patients with vertebrobasilar vascular disease. Two had locked-in syndrome, and one had vertebral ischemia with abnormality in interwave latencies.

In the present study, we evaluated dizziness in patients at an average age of 55 years. All patients underwent a complete neurological, otological evaluation and various laboratory studies, including brainstem evoked potentials. The most common cause of dizziness was found to be peripheral labyrinthine dysfunction. Multiple sensory defects also were noted to be high on the list.

For a significant number of patients who complain of dizziness and in whom other investigations are unrewarding, use of brainstem evoked potentials showed that brainstem dysfunction is the underlying cause of their symptoms, as it had been shown in patients with post-concussion dizziness. The etiology of these abnormal evoked potentials appears to be vascular; however, other etiologies of brainstem dysfunction should be sought. Angiography can be considered in selected cases to look for surgical correctable lesion, and wherever applicable, anticoagulation may be instituted to prevent brainstem infarction.

References are available from Dr. Ahmed, Neuro-Diagnostic Laboratory, St. Mary's Hospital, 101 Memorial Drive, Kansas City MO 64108. →

Post-Splenectomy Sepsis

(Continued from page 120)

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An additional bibliography is available on request from Dr. Vats, UKSM-KC, 39th & Rainbow Blvd., Kansas City KS 66103. →

PRESIDENT'S MESSAGE

As I reflect on the year of my presidency, which is rapidly coming to a close, I want to share several observations and conclusions.

The practice of medicine is in a constant state of flux with ever-changing parameters. As I've said many times, it seems that problems never change — just the names thereof.

We started the year with the passage of HB 2661 with which you're all familiar. The housecleaning legislation to correct some errors in the original bill has been introduced. The constitutional test of this bill remains somewhere in limbo and has yet to be resolved.

The Kansas Foundation for Medical Care has been a major concern, and we hope some progress has been attained in this area.

The collateral source rule — passed in 1985 — was challenged, and a final second ruling on this issue — *i.e.* its constitutionality — is also still pending.

The issue as to whether the word "physician" can be used by chiropractors has been decided by Attorney General Stephan in favor of the Medical Society; *i.e.* chiropractors may *not* use the word physician with the word chiropractic.

Unified membership has been discussed constantly for the past year and will be a major topic at the annual meeting in Manhattan next month.

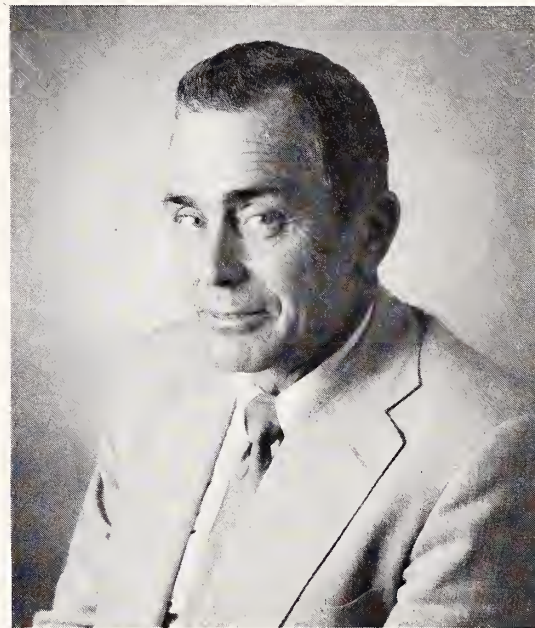
Malpractice insurance costs have been, still are, and undoubtedly *will* be of continuing concern for all of us. In spite of all the effort by everyone, we really don't anticipate any premium reductions — and in fact, can expect some increases during the next two to three years.

On the more positive side, KMS initiated its own subsidiary for-profit corporation in an attempt to produce more non-dues income.

Considerable time and effort has been and is continuing to be spent in evaluating the potential benefits of a statewide IPA for the physicians of Kansas.

The above mentioned issues are not all-inclusive of the activities of KMS this past year, but do include some of the major ones.

As painful as it was, I had to realize that the wheels of political progress turn very slowly and many times only increase our frustrations.



I would like to take this opportunity to publicly thank all the physicians with whom I have worked this past year, especially the members of the Executive Committee, councilors, and committee chairmen. Needless to say, without the KMS staff headed by Jerry Slaughter, I would have accomplished nothing.

Thanks to all of you KMS members who have been so supportive. May God be with all of us for a successful next year.

Ats Bickelmeier MD

President



EDITORIAL COMMENT

The Right Stuff

AT A TIME when medicine is beset by constant inroads on traditional principles and practices (not to mention payment), the older convictions are threatened in a radically new world. An underlying current of malaise seems to stem from uncertainty of determining the appropriate ethical concepts as they have prevailed in the past. Perhaps the difficulties the old principles find in adapting to the new age reflect the problem that afflicts any aging entity (human or otherwise) in adjusting to the social realities of the present — and prospects for the future.

But ethics are presumed to be ageless, immutable, if the basic discipline is valid. Perhaps the problem lies with the agents rather than the discipline. For most of us, indoctrination into the realities of medical practice, embodying those ethics (as they do), was based first on a desire to assume the responsibilities, then to expend the effort necessary to learn the methods, and finally to expend the effort in practice. In moving into each stage, the process revealed the nature of medical ethics in finer focus as their application moved from philosophic challenge to painful reality. The medical curriculum did not carry any formal or prescribed course of ethics — what they were and how to ease the process. They were just *understood* — meaning, of course, that they became confused with bordering ethical considerations — religious, cultural, even legal, not to mention personal interpretations.

Today, increasing attention is being given to the idea that medical ethics can and should be taught, an outstanding proponent being Dr. Edward Pellegrino, one of the country's leading ethicists. Basic to the idea is the definition of "profession" to which he gives a succinct functional form. It is different from other careers in that "when a difficult decision is to be made, you can depend on one who is in a true profession to efface his own self-interest," as distinguished, for example, from a businessman "whom you do not expect that from." But there are other professions answering the general qualification, so what makes physicians different? We

suggest it is the close and unique interrelationship of the physician with the patient's physical and mental (and hence moral) well-being in a form and degree no other profession matches.

There has been, then, this uncertainty about the current structure and application of medical ethics which has produced unfortunate effects within the profession as circumstances have forced their reinterpretation. The conditions confronting us, whether of our own making or not, have created demands for changing ethical emphasis in different areas of medical practice which have been divisive. Perhaps the lack of a rigid definition of ethics in their application accounts for a confusion, even invasion, of other ethical concepts into medicine — or is it in reality made up of all of them? Rather than medical ethics determining the practice, the pressures of adapting to this complicated society are shaping the ethics.

Perhaps it could be no other way considering the problems of a world growing in population and technologic reliance and communication as the older boundaries of race and nation and moral concepts become dimmer. Many — perhaps most — of the projections of the physician's role in the future point to a far different one in regard to patient relationships than we think characteristic today. If this is true (and to the extent that it is), it will continue to require some unpalatable adjustments to avoid becoming ineffectually anachronistic.

What, then, will the ethical substance of the profession be? Will it retain that certainty, that when a difficult decision is to be made, it will efface its own self-interest in favor of that of its patients? Will it continue in the direction of "business"? The general interpretation now is that methods of quality (although they have undergone alterations by the socioeconomic demands) must be maintained relentlessly — for the patient's welfare, not the profession's. The basic principle may be true but can the practice of it stand? — D.E.G.



Patient Records

WAYNE T. STRATTON, J.D., *Topeka*

MEDICAL RECORDS are a formal history of a patient's course of treatment. The record communicates information as well as memorializes action taken by the physician.

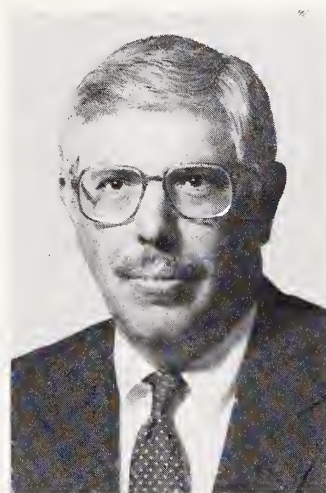
Hospital records have been subject to various rules and regulations governing their content. Now, physician records in Kansas are subject to similar regulation. Effective December 19, 1986, licensees of the Board of Healing Arts must comply with K.A.R. 100-24-1, which sets forth the minimal requirements for an adequate patient record as follows:

Each licensee of the board shall maintain an adequate record for each patient justifying the course of treatment of the patient. Each patient record maintained shall be considered to be adequate and in compliance with this regulation if it conforms to the following minimal requirements:

1. It is legible;
2. It contains only those terms and abbreviations that are comprehensible to similar licensees;
3. It contains adequate identification of the patient;
4. It indicates the dates any professional service was provided;
5. It contains pertinent and significant information concerning the patient's condition;
6. It reflects what examinations, vital signs and tests were obtained, performed or ordered, and the findings of each;
7. It indicates the initial diagnosis and the patient's initial reason for seeking the licensee's services;
8. It indicates the medications prescribed, dispensed, or administered and the quantity and strength of each;
9. It reflects the treatment performed or recommended; and

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE or the Kansas Medical Society. For further information, contact Mr. Stratton, 215 E. 8th, Topeka KS 66603: 1-800-332-0248.



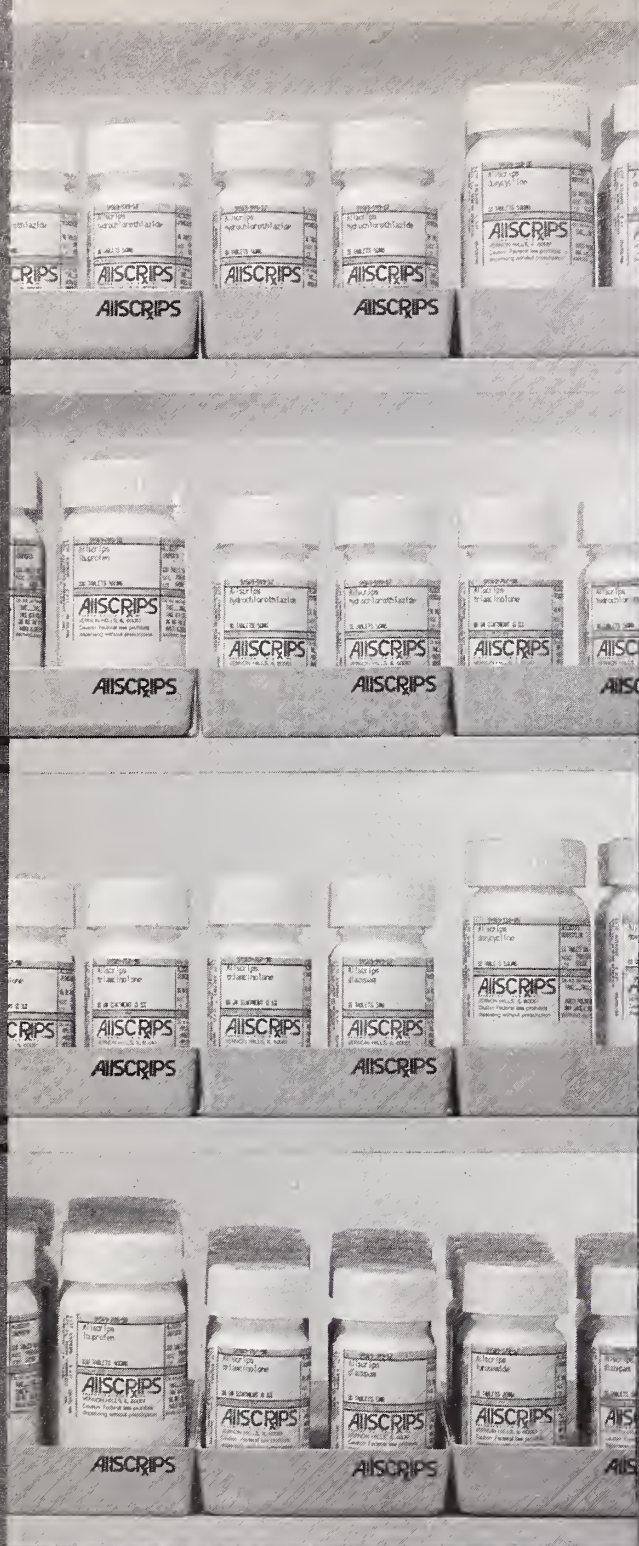
Mr. Stratton is legal counsel for the Kansas Medical Society. His discussion topics are selected for their medicolegal interest to physicians. Readers are invited to submit questions or items of interest in this area for attention in this series.

10. It documents the patient's progress during the course of treatment provided by the licensee.

In addition to governing the content of the patient record, the new regulation mandates that patient records shall be maintained for minimum of ten years after the date that any professional service was provided. The licensee may designate another party to maintain the records.

Since this regulation imposes a personal requirement upon licensees of the Board of Healing Arts, the regulation impacts upon other patient records. For example, it appears that physicians must comply with the Board of Healing Arts regulations when they make records at hospitals and nursing homes.

Medical records are not only an essential tool for practitioners in treating patients, but can serve as vitally important evidence in the event of subsequent litigation. The Kansas Supreme Court has permitted a plaintiff's attorney in a malpractice case to offer evidence of regulatory violations to prove negligence. It may be expected that lack of compliance with the regulation recently adopted by the Board of Healing Arts may be offered in the future to prove dereliction on the part of physicians. It is therefore crucial that the regulation is complied with in its entirety. →



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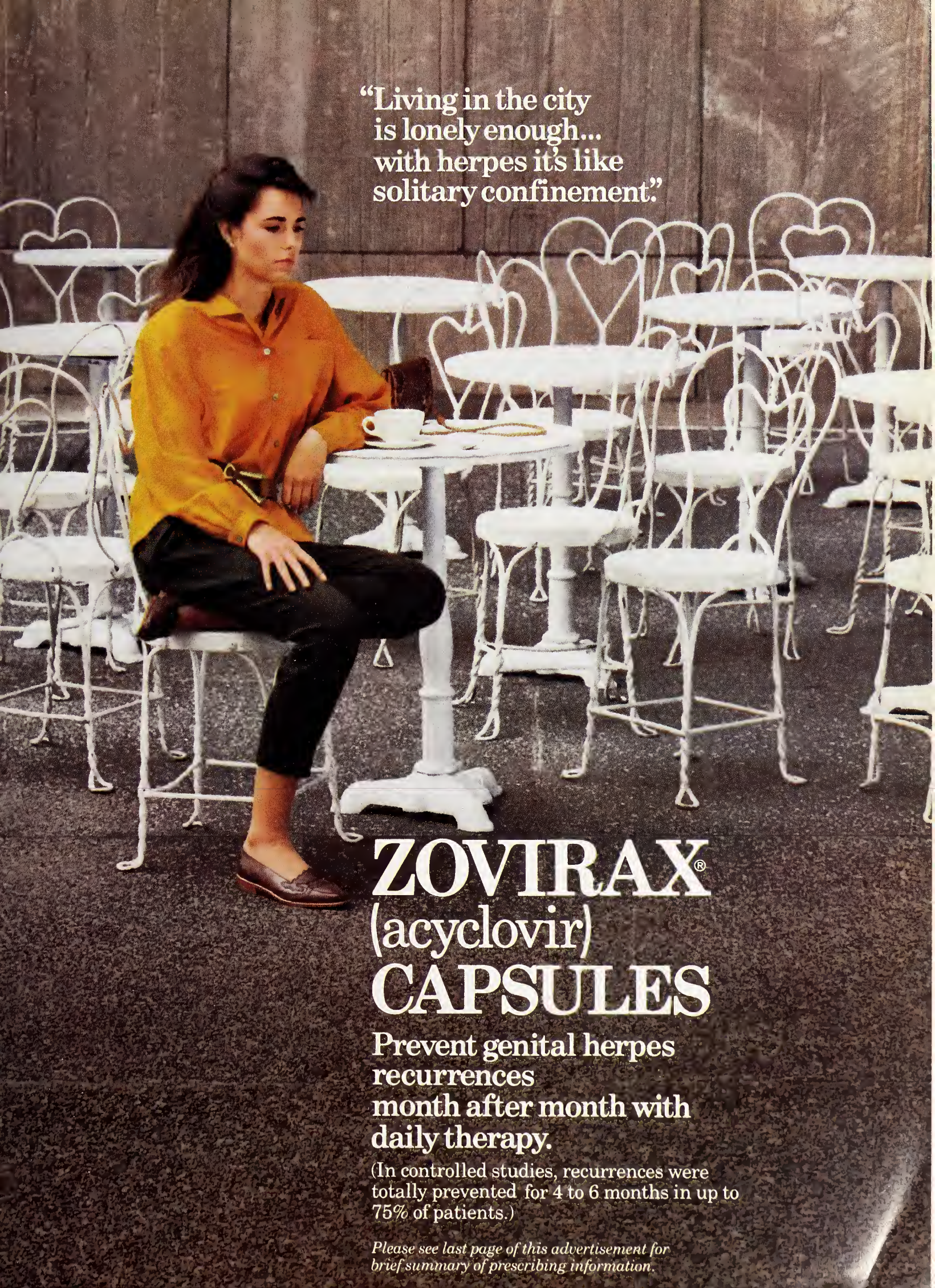
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month after month with
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(In controlled studies, recurrences were
totally prevented for 4 to 6 months in up to
75% of patients.)

*Please see last page of this advertisement for
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**Help free your
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recurrences.**

Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks — month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

Generally well tolerated

Daily therapy with ZOVIRAX CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/vomiting, vertigo, and arthralgia.

The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

*Please see brief summary of
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Prevent recurrences month after month^{*} **ZOVIRAX[®]** (acyclovir) **CAPSULES**

Brief Summary

INDICATIONS AND USAGE: Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psychosocial difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

First Episodes (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

Recurrent Episodes:

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This

approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

CONTRAINDICATIONS: Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

WARNINGS: Zovirax Capsules are intended for oral ingestion only.

PRECAUTIONS: General: Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

Drug Interactions: Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F₁ generation. Although not statistically significant,

there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week post-dose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS — Short-Term

Administration: The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

Long-Term Administration: The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

Chronic suppressive therapy for recurrent disease: One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

Intermittent Therapy: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

Patients With Acute or Chronic Renal Impairment: One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance ≤ 10 ml/min/1.73 m².

HOW SUPPLIED: Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200" - Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

^{*}In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.



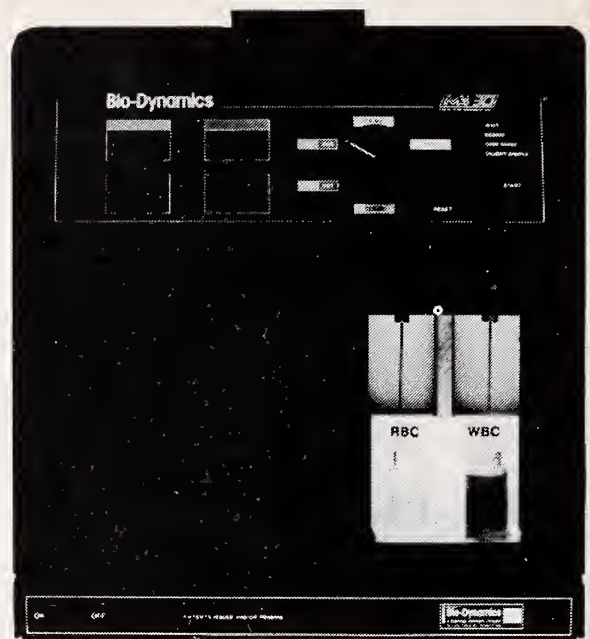
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HSV & HPV

(Continued from page 115)

cogene expression in 75% of cervical carcinomas with HPV 16 or 18 DNA.⁷⁵ Often more than one oncogene is associated with transformation of cells⁷⁶; thus it seems reasonable that HSV and HPV may activate different mechanisms, perhaps oncogenes, to cause cervical neoplasia.

Patient Management

Regardless of the molecular mechanism of carcinogenesis, patients with genital HPV and HSV infections are at increased risk for the development of cervical neoplasia. These patients require careful clinical and cytological study to identify the early neoplastic changes of CIN. Pap smears are necessary at least annually for this high risk group. The demonstration of atypical or dysplastic changes necessitates more intensive investigation with colposcopy and biopsy. In fact, a strong case could be made for routine colposcopy for patients with known genital HSV or HPV infections. As technology permits the development of techniques to identify specific viral subtypes, such as HPV 16 and 18, cells obtained from a cytological smear may provide even more specifically directed screening.

Because of sexual transmission, the consorts of women with HPV infections should be examined with acetic acid and magnification, similar to colposcopic examination of the cervix. Papillary lesions, which are usually grossly obvious, generally respond to chemical therapy (podophyllin, trichloroacetic acid). Flat condylomata will be missed without acetic acid visualization. When found they must be treated with laser or cryosurgery, as they do not respond to chemical treatment.

Only aggressive diagnosis and therapy for CIN will prevent the development of invasive squamous cell carcinoma in this high risk group of patients. It should be recalled that CIN, adequately treated by surgical excision, cryotherapy or laser therapy, has a 100% survival rate; but that invasive squamous cell carcinoma, even with early diagnosis, has a poorer prognosis. Apparent successful therapy of CIN requires continued followup, since recurrence of CIN in 5-10% of patients may require additional local therapy and/or more aggressive therapy, including conization or hysterectomy. The frequent identification of CIN in younger age patients, who may desire future child bearing, requires the consideration of the consequences of therapy and necessitates long term patient evaluation and followup. Only by the identification of high risk HSV

and HPV positive patients, and by their timely evaluation and treatment, will the subsequent development of squamous cell carcinoma of the cervix be prevented and/or treated at an early stage.

Reading List

(This is a list of readings on this topic. A complete list of references is available from Dr. King, UKSM-KC, 39th & Rainbow Blvd., Kansas City KS 66103.)

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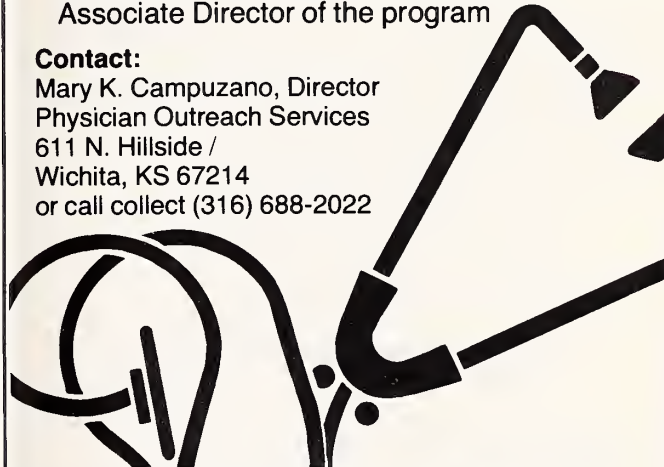
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to find
just the
right room.

60,073 patients (90%) who started on INDERAL[®] LA stayed on INDERAL LA.^{1*}

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Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.

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(PROPRANOLOL HCl) LONG ACTING CAPSULES

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

The one you know best keeps looking better

Please see next page for brief summary of prescribing information.

The one you know best keeps looking better

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)

INDERAL® LA brand of propranolol hydrochloride (Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. Inderal is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of Inderal has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. Inderal has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, Inderal also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: Inderal LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior

to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. General: Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Inderal is excreted in human milk. Caution should be exercised when Inderal is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal tablets to Inderal LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg for mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg Inderal LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

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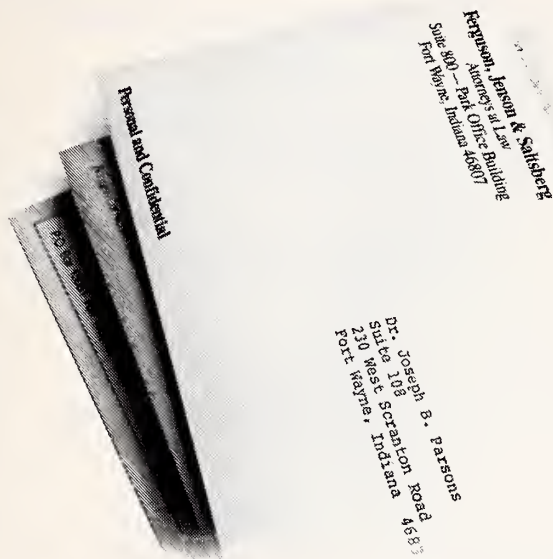
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Classified advertisements are \$5/line for KMS members; \$7.50/line for non-members; 5-line minimum. Payment must accompany copy. Deadline is 20th of the month preceding month of publication. Box numbers are available at no charge. All advertisements are accepted subject to approval by the Editorial Board.

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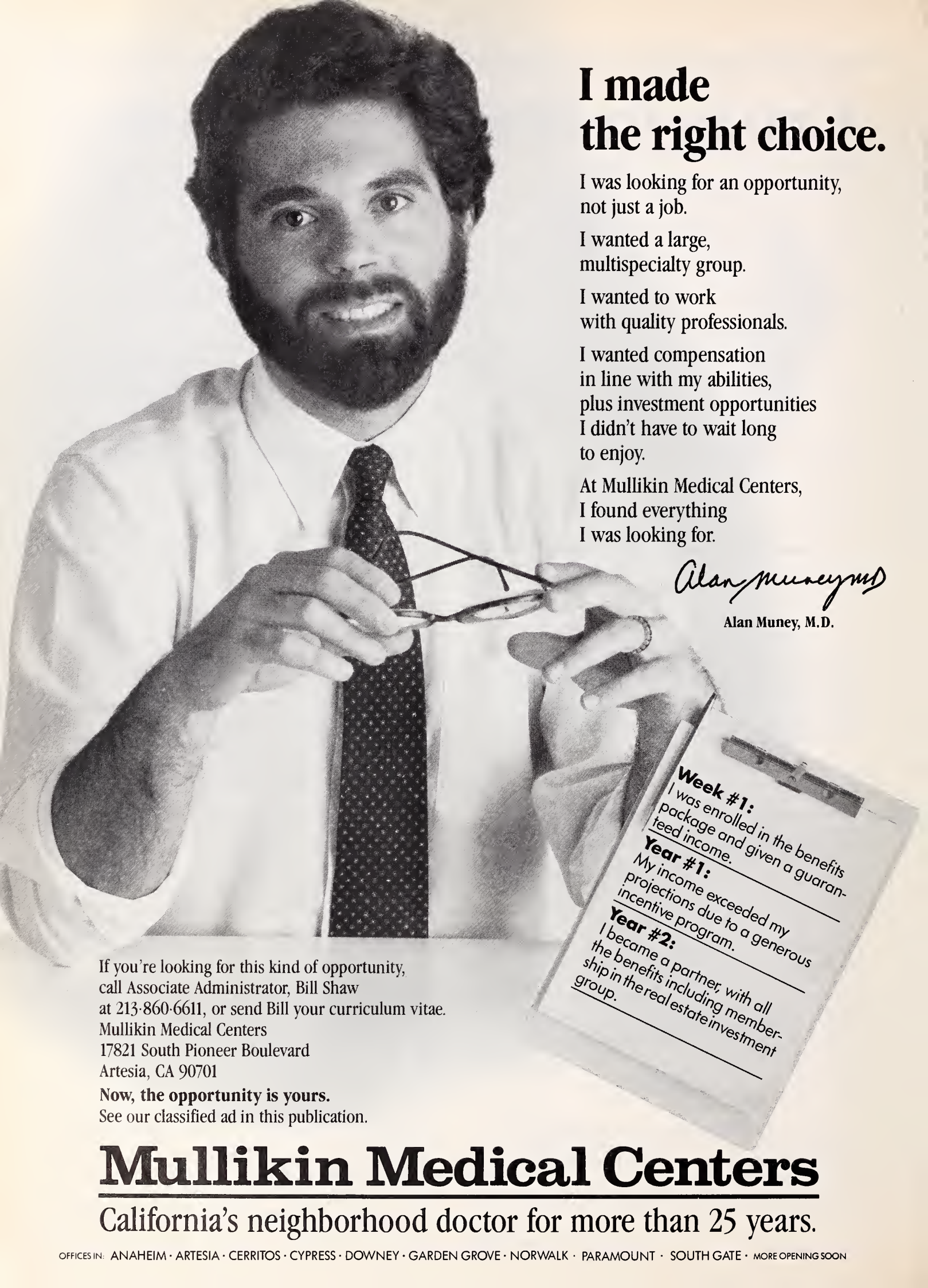
Foreign Bodies

(Continued from page 118)

sphincter which initially relieved the patient's symptomatology. Esophageal dilatation further eliminated the patient's problem. There have been no recurrences, and the patient remains asymptomatic.

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VOX DOX

To the Editor:

I want to express my appreciation for and agreement with your Editorial Comment — “The Unrelenting Obligation” — in the February issue of KANSAS MEDICINE. I am involved in many malpractice suits, one-third of them with non-psychiatrists, so I am aware of the relevance of your comments. I also see a lot of accident cases (personal injury — traumatic neurosis) and I say or write every time I have a chance that injury may happen to tissues, but accidents happen to people. I would like to see more physicians treating accident victims rather than just bruised muscles or fractured bones.

The sudden, unexpected accident can be a very disruptive, psychologically traumatic experience that punctures one's belief in his/her invulnerability and the assumption that the person has charge of her/his life. Support, understanding, and reassurance at such a time can be reparative and prophylactic.

Keep up the good work.

Herbert C. Modlin, M.D.
Noble Professor of Forensic Psychiatry
The Menninger Foundation
P.O. Box 829
Topeka KS 66601



Response — “Quality?”

(Continued from page 110)

KFMC isn't CAUSING the problems of inadequate medical care in Kansas, it is merely FINDING some of them.

Inefficient? Yes. Assuredly. We are directed by government, after all. When government gets efficient, watch out!

Harassers? No. We are just trying to provide “due process.”

Bureaucratic power thirst? Unprofessional and immoral neglect? These are expressions that slander is made of!

As disgusted as I was with the editors of KANSAS MEDICINE for printing such an article (obviously unedited and uncut), I am even more aghast to note, via a footnote, that this trash was first “laundered” in the public press, i.e. *The Wellington Daily News*.

I am ashamed for my profession!

FAMOUS PHYSICIANS ARE SHOWING UP FOR OUR 40th YEAR CELEBRATION.



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Read Every Issue From Cover to Cover:

April

Symposium: Focus on General Internal Medicine Faith T. Fitzgerald, M.D.
coordinator

Special Article: General Internal Medicine 1947-1987 Richard L. Byyny, M.D.

May 1

Symposium: Diabetes Mellitus

Special Article: Diabetes Mellitus 1947-1987 Frederick C. Goetz, M.D.

May 15

Symposium: Hypertension Frank A. Finnerty, Jr.
coordinator

Special Article: Cardiology 1947-1987 J. Willis Hurst, M.D.

June

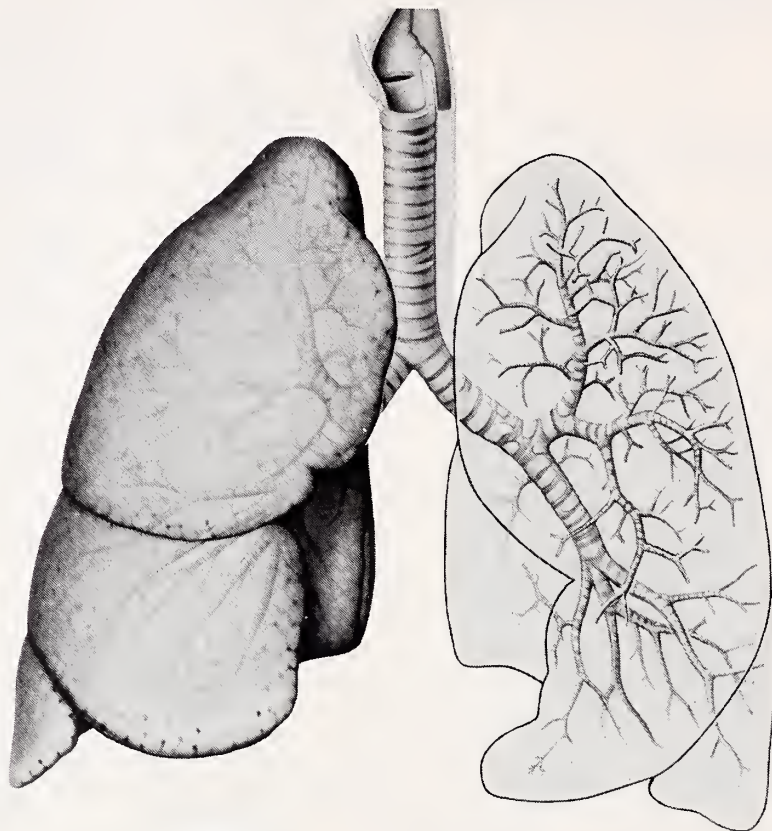
Symposium: Orthopedics in Primary Care

Special Article: Orthopedics 1947-1987 Paul P. Griffin, M.D.

40-YEAR
Postgraduate
Medicine

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Ceclor[®] cefactor

250-mg Pulvules[®] t.i.d.

**offers effectiveness against
the major causes of bacterial bronchitis**
H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor[®] (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, manage-

ment should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: General Precautions — If an allergic reaction to Ceclor[®] (cefactor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids. Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix[®] tablets but not with Tes-Tape[®] (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — **Pregnancy Category B** — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum

human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor[®] (cefactor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have

occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor[®] (cefactor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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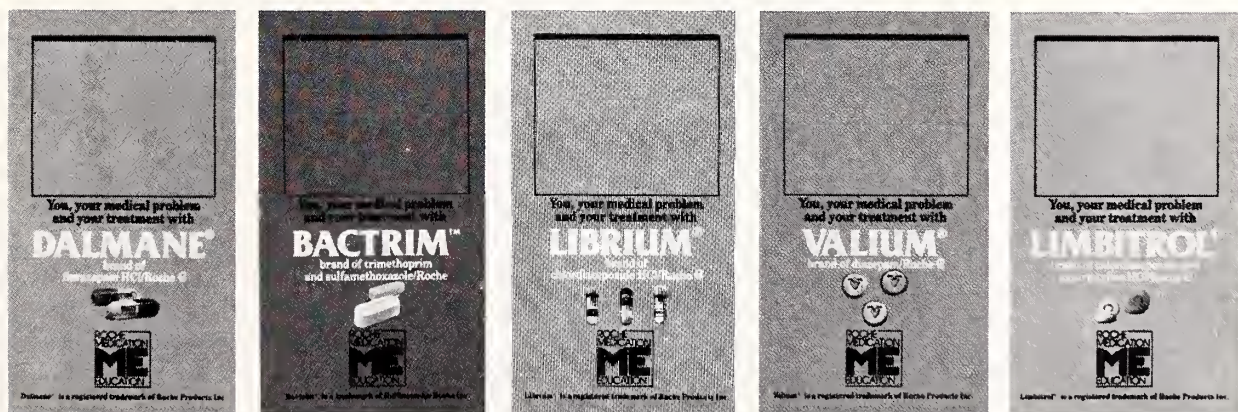


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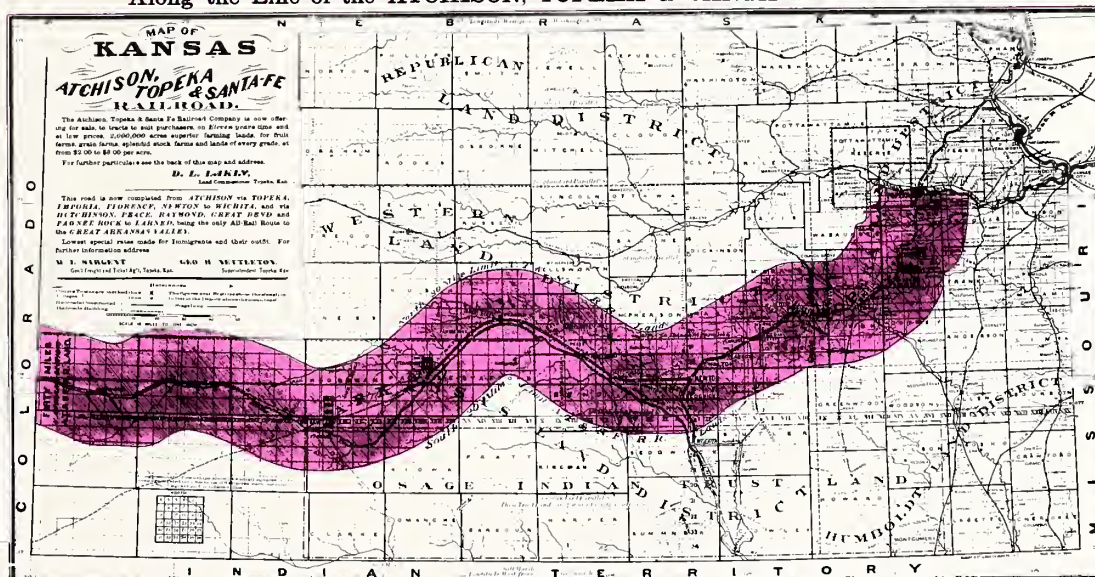
KANSAS MEDICINE

Volume 88, Number 5, May 1987 ISSN 8755-0059

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The newly-built Santa Fe railroad with a map of 1872 advertises its Kansas land holdings and its availability for shipping the cattle now being trailed north from Texas, calling itself "the favorite stock road of Kansas." Below, 19 years later, a rival railroad signaled the transformation of the old buffalo range and advertised for sale its "golden belt" wheat lands.

Cover story — page 139

Urethral Hymenal Fusion	150
Aortic Surgery in Octogenarians	154
Residency Followup	155
Facing Cancer Together	159
Stress Management in Residency	162
Anatomy of an Epidemic	142
KMS Newsletter	156a

THE JOURNAL OF THE KANSAS MEDICAL SOCIETY

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KANSAS MEDICINE

• The Journal Of The Kansas Medical Society •

Volume 88, Number 5, May 1987

Contents

Scientific Articles

- Urethral-Hymenal Fusion & Recurrent UTI — Steven Keith Lawton, Shawnee Mission
Operative procedures may give relief to some women who experience chronic urinary problems related to intercourse 150
- Mortality of Elective Abdominal Aortic Surgery in Octogenarians — Alex D. Ammar, M.D., Wichita
Results of this study indicate that major vascular surgery should not be withheld on the basis of age alone 154
- Graduate Followup of UKSM-KC Family Practice Residency Training — James G. Price, M.D. and Bruce S. Liese, Ph.D., Kansas City, Kansas
Data obtained in this survey will guide future planning for the Family Practice Residency Training Program 155
- Facing Cancer Together: A Volunteer Program for Small Communities — David W. Bouda, M.D., Hutchison
Outlined here is a plan for a support program for cancer patients based on guidelines from the American Cancer Society 159
- Stress Management in Residency Training Programs — Herbert R. Goldberg, M.D., Wichita
It should not be necessary for a resident to lose his or her health in order to gain the knowledge and training to protect and restore the health of others 162

Special Feature

- Anatomy of an Epidemic — David E. Gray, M.D., Topeka 142

Miscellaneous

- Auxiliary News 148
- Classified Advertisements 176
- Continuing Medical Education 170
- Cover Story 139
- Editorial Comment: *Spreading the Word* 165
- Impaired Physician Program Resource List 172
- Information for Authors 176
- KFMC Update 140
- KMS Newsletter 156a
- Medicina et Lex: *Antitrust Immunity for Reviewers* — Wayne T. Stratton, J.D., Topeka 166
- President's Message 164

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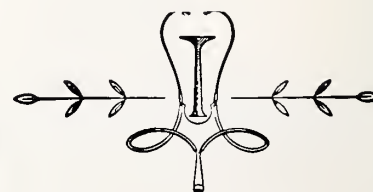
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In August, KANSAS MEDICINE will again publish the KMS membership directory. Please check to make sure we have accurate up-to-date information for your listing.

If you have questions about your listing or want to make a correction, please contact:

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Each KMS member physician will receive one copy as a benefit of membership. Extra copies are available to members at \$12 per copy. Hospitals and clinics may also order copies at \$12 each. Others may purchase them for \$25 per copy.

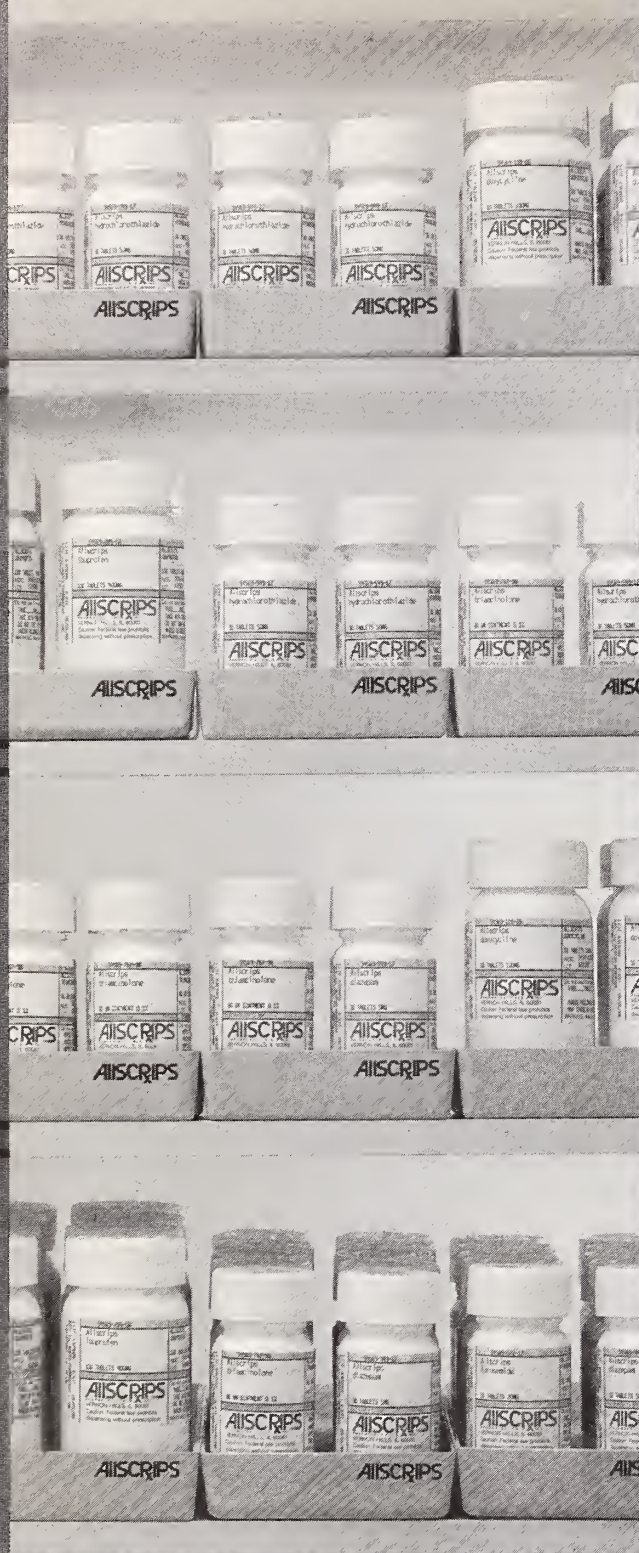
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Intraocular Lens Warning

The American Academy of Ophthalmology has called attention to the occurrence of vision problems in recipients of certain anterior chamber intraocular lenses. Although the majority of patients have experienced no complications, the risks to those affected warrant the advice to physicians generally who may receive questions about the procedure or the lenses, as well as ophthalmologists involved in the use of such lenses (who have undoubtedly been aware of the problems previously).

The following lenses as well as others have been reported as being involved:

**Azar 91Z IOLab (voluntarily
withdrawn from the
market)**

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Cover Story

The railroads were contributors and beneficiaries, producers and products, financial influences for good and bad, cultural conditioners, and ethnic forces in the developing territory and state of Kansas. In the process of providing a new way of life, they hastened destruction to the old. Above all, they were a means to an end since the essential element in the total process was, as always, people.

Isolating any one factor as the most important in their development is impossible. Certainly, the gold strikes in California caught the attention of the East and led to the government's Pacific Survey to determine the best routes to that area (and, incidentally accounts for the word, "Pacific," tacked onto the names of many roads). Since Kansas was squarely in the way, it inherited much attention as efforts pushed out from several Missouri River communities.

Many of the roads whose names survive existed only on paper, lack of money or interest (meaning money) leaving them there. Many were, by present standards, short stretches (there were at least 17 different roads at one time) and their names were all but lost as they were absorbed by larger companies now known to later generations — the Union Pacific, Santa Fe, Rock Island, Missouri Pacific and Katy (originally the southern division of the Union Pacific as the Kansas Pacific was its central line).

Demand for safer and more rapid transportation of Texas cattle to the eastern markets led to the development of railheads to which the cattle could be brought and gave rise to innumerable legends.

The financing of the roads was both burden and bounty to the state and legislators were personally involved or well acquainted with lobbyists from the various roads. Labor unions were on the rise and brought their economic and social impact. The developing telegraph was a vital form of communication for the railroads' business, and the station agent became both reporter and conveyer of news. Towns sprang up and grew on the strength of their proximity to the lines while others without this sustenance went out of existence.

Railroads played a role in the medical service, connecting physicians to distant patients and to each other as, for example, the development of societies including the Kansas Medical Society. A frequent part of the Secretary's Report at the early annual meetings was to inform of the favorable rates provided by one or another of the lines to assist them in getting to the meetings.

Railroad advertisements proclaimed the attractions of the area — buffalo hunting, gold-seeking — land (as shown on the cover from Baughman's *Kansas in Maps*, courtesy of the Kansas State Historical Society).

This last inducement to the roads' expansion was abetted by the government's land grant policy: for every mile of track laid, 20 square miles of land was given to the road. Moreover, this could be taken in accordance with the custom of homesteading days: checkerboarding. By taking their land in checkerboard fashion, they could enclose other areas which others could not get at. In addition, the government offered to the first road reaching the 100th meridian the blessing of continuing on to the coast.

This availability of cheap land led the railroads to promote their holdings as farm and home sites to Easterners and Europeans. This became a major factor in bringing to Kansas the remarkable complex of interests and nationalities and dedication to a better life that has made it what it is today.

Support KaMPAC

KFMC UPDATE

KFMC and Quality Review

I HAVE recently received a number of questions from physicians around the state about KFMC and its Quality Review Program. Many believe KFMC is making denials of Medicare payments for identified quality problems, as specified in recent legislation, but this is not true in Kansas, nor in any state to my knowledge.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 caused considerable concern and confusion by mandating not only PRO denial of payment for cases with significant quality problems, but that the attending physician, facility, and Medicare beneficiary must be notified of the denial. This has raised questions in all areas of health care about what will happen when beneficiaries are given such notices.

The program was to have gone into effect January 1, 1987, but has been indefinitely delayed pending legislation clarification and development of program regulations. Therefore, no PRO has the authority to issue denials for quality problems and, at this point, no one knows when, or if, that will happen.

KFMC does review quality of care, and has since the Foundation's beginning. However, that review has been generally overshadowed by its utilization

counterpart. Denials of Medicare payment for inappropriate utilization have the effect of getting everyone's attention by affecting practitioners and facilities alike. Cases identified as quality problems, however, have been handled confidentially between KFMC and the attending physician, and involves a facility only if a significant pattern of problems is found.

KFMC's protocol for identifying and intervening in quality problems has been significantly modified and formalized in the last several months. That formalization includes a classification system to rank the severity of the quality problem and a sequencing of interventions initiated by KFMC to correct it.

A significant difference in quality interventions from past years to present is the emphasis placed on quality questions. As a result, the PRO authority to recommend Medicare program sanctions for a physician (or facility) if a verified quality problem is gross and flagrant or goes uncorrected has been expanded. KFMC views sanction recommendation as a "last resort" and does not lightly enter into this activity. Except in those instances where initiation of a sanction is mandated by the government, KFMC always attempts problem correction through physician-to-physician contact and education.

As KFMC receives more information about new review responsibilities, I will keep you informed. If you have questions concerning KFMC's quality review program, please contact the Foundation.

In keeping with its policy of offering continuing information regarding medical activities, KANSAS MEDICINE presents a serial offering prepared by G. Rex Stone, M.D., Medical Director of the Kansas Foundation for Medical Care.



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Read the KMS NEWSLETTER, page 156a, to keep
abreast of critical issues.*

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hypertensives stayed on

INDERAL[®] LA
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An aerial photograph of a large, modern stadium at dusk. The stadium is filled with spectators, and the soccer field is brightly lit. The surrounding area includes parking lots, roads, and a cityscape in the background under a twilight sky.

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*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

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Please see next page for brief summary of prescribing information.

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® LA brand of propranolol hydrochloride (Long Acting Capsules)

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. Inderal is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by Inderal, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

Inderal LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with Inderal LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of Inderal Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

Inderal LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to Inderal LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, Inderal LA has been therapeutically equivalent to the same mg dose of conventional Inderal as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. Inderal LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: Inderal LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. Inderal LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: Inderal LA is indicated for the long-term management of patients with angina pectoris.

Migraine: Inderal LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: Inderal LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. Inderal LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. Inderal is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first-degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or Inderal should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of Inderal therapy. Therefore, when discontinuance of Inderal is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

Inderal (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3 , and decreasing T_3 .

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. Inderal (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should

be told that Inderal may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenyltol, phenobarbitone, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. Inderal has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. Inderal should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: Inderal is excreted in human milk. Caution should be exercised when Inderal (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. Inderal LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from Inderal Tablets to Inderal LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. Inderal LA should not be considered a simple mg-for-mg substitute for Inderal. Inderal LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg Inderal LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg Inderal LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg Inderal LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, Inderal LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg Inderal LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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REFERENCES:

1. Inderal LA National Compliance Evaluation Program. Data on file, Ayerst Laboratories.
2. Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985; 145:1321-1323.

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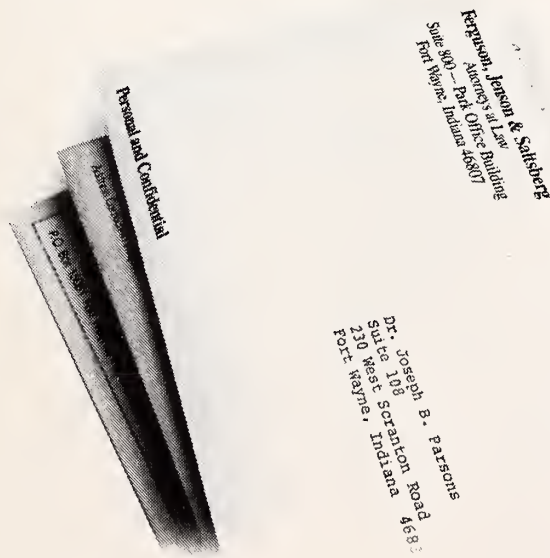
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SPECIAL FEATURE

Anatomy of an Epidemic

DAVID E. GRAY, M.D., *Topeka*

IT IS A story of three parts — the scourge, the place, and the man.

The scourge was one of mankind's oldest — smallpox. A century earlier, the possibility of being protected against it was just emerging with Edward Jenner's observations. A century later, the world would cautiously begin to believe that it might be a thing of the past as it became first a medical curiosity and finally, as distant reports came in, extinct. But in 1872, it was very much a reality, a continuing presence among people and bitter challenge to physicians.

The place was Silver Lake, a small but proud community in western Shawnee County which was sure its location on the north bank of the Kaw would bring it great things even as it was then a crossing point for the river as well as a tie-up spot for the river traffic. It claimed some 1300 or more inhabitants although the figure for some reason included Rossville, its smaller neighbor to the west. It had the usual commercial appurtenances including a general store whose owner, in true entrepreneurial fashion, let out rooms upstairs over the store and functioned as a self-proclaimed doctor.

But this was not the man. The man was Dr. H. K. Kennedy of Topeka who recorded in detail the events that brought Silver Lake passing but unwanted attention. He was well qualified to report the matter being at the time director of the pesthouse in Topeka (and the fact that there was such an institution is testimony to the constant presence of contagious threats in that day). Furthermore, he reported the events at the 1873 annual meeting of the Kansas Medical Society — even as he was being elected to the presidency of the organization for the coming year. His paper, as is the custom still in medical papers, went well beyond just telling this story but touched as well on the prevalence of smallpox in the country at the time and, in particular, his strong faith in effective vaccination as well as his opinion of the "specifics," those palliative measures still

relied on in a world where vaccination was poorly accepted at best and, in its crude state, less effective than it would become.

It began, so Dr. Kennedy relates, when a resident of Wabaunsee County (to the west) returned from a trip to St. Louis. This was S. H. (Dr. Kennedy, with proper respect for confidentiality, uses only initials). After S. H. had been home less than a week, he became ill. After a few days of self-treatment, he was seen by a doctor who pronounced it "bilious fever." After being sick 11 days, H. died. A man, R., who had nursed him became sick several days later. He proceeded to Silver Lake where he took a room in the versatile shopkeeper's establishment. The evidence of smallpox appeared the next day and he died on the 12th day. The same week, the merchant's clerk became sick and was taken to the pesthouse, his course thereafter being unmentioned.

R. having died, T. assisted in his burial, became the next victim, and died on the 11th day. Meantime, W. purchased a suit at the store but, going on a spree, went home without it. He fell ill 12 days later, dying on the 13th day of illness — although capriciously the disease did not affect any of the seven family members living in the one-room house. Next, Mr. O. purchased an overcoat at the store, wrapping his small daughter in it to take her to school. She became sick but recovered while a sister, also a victim, died on the 13th day.

Business remained good (enough, at least) at the store. A Negro man purchased some articles and returned to the home of E. where he was living. A few days later, the eruption appeared and he was taken to the pesthouse where he died on the 11th day. The eight members of the E. family all came down with the disease, presenting the entire range of manifestation, but all survived. Although their contact with other cases is not recorded, the all-adult family of C. including four children and a nephew became victims, the nephew and three of

the children dying before the 14th day.

The family of W. — a different W. apparently — the parents and five children, were the next cases reported. Mrs. W. and four of the children died although the mother and two of the children presented no eruption. Dr. Kennedy attributed the scant evidence of the disease in these and some other cases as "want of vitality." The family lived on the shore of the "pond" that gave Silver Lake its name, and this lack of vitality was attributed to "malarial poison in the system."

At this point, the disease seems to have diminished in Silver Lake, perhaps for want of susceptible victims or what seemed to Dr. Kennedy to be part of its capricious nature, but it wasn't finished for it spread eastward to Topeka as visitors came and went — probably farther, too, although no reports of an outbreak elsewhere in the state have been found, perhaps a tribute to Dr. Kennedy's interest and history taking on the local scene. Although there were cases handled by other physicians, Dr. Kennedy's position at the pesthouse gave him a front row seat. Among the cases he tells of are Mrs. P. and her family including two children who became sick and died. Transmission was blamed on a son of the family from which Mrs. P.'s daughter had first contracted the disease but, by way of unhappy retribution perhaps, the young man also died. Mrs. P.'s sister, living in the home, called on the T. family following which visit T. became ill and died on the 13th day. Although Mrs. T. and their six children became ill, all recovered.

As the Silver Lake experience was abating, then, Dr. Kennedy could turn his attention more to other things, primarily the situation at the pesthouse where, he reported, there were 36 cases with four dying, two of whom had been in his care less than 30 hours. His sometimes rambling account of those days makes a total count difficult but the Silver Lake toll apparently was 17 dead and 14 survivors of those afflicted. In the entire county, he reports 105 cases with 20 deaths.

Dr. Kennedy used his captive audience to drive home his interest in promoting controlled vaccination although he remained disturbed by the seeming discrepancies between theory and the experience. At the time, the germ theory was not wholeheartedly accepted by the profession. Despite the glory that would come to Louis Pasteur and others later, much of the profession was not inclined to believe these tiny beasts could cause disease — although they referred to "viruses," it was more a generic toxic classification only vaguely related to the concept of

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viruses as it would develop later. Furthermore, the complications and failures of vaccines then available as well as direct inoculation from an active case were troublesome to those of Dr. Kennedy's mind. Even exposure to a case without inoculation was tried in the hope of inducing a mild but immunity-endowing illness.

These uncertainties of vaccination and the vagaries of the disease may have led to his frustration and unconscious reluctance to go deeper in presentations such as his. Referring to his experiences that didn't conform, he says defensively, "I cannot help that; am only reporting the facts as they occurred in my practice in the past winter; do not pretend to explain the causes; leave that for the curious in such matters." This did not mean he was not interested in finding the best remedy for the disease. In general, the various treatments were directed toward the symptoms with the hope that a "specific" cure would emerge somewhere along the line.

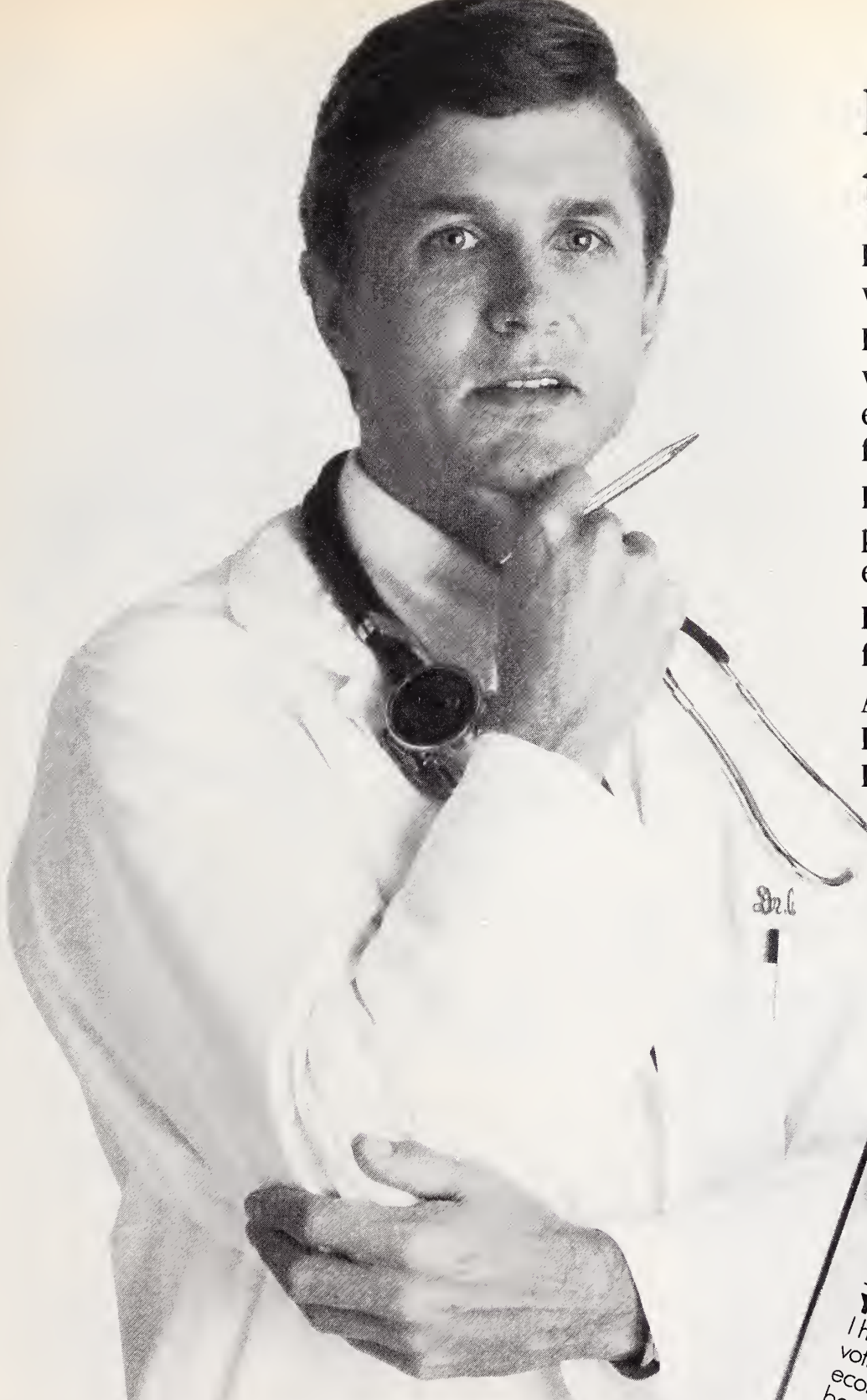
So it was that the list of "specifics" for smallpox was, by virtue of its long history and persistence, extensive and diverse. Among them were xylol, vinegar, cohose, and the sulfites and the individuality of personality of physicians was often displayed by the promotion of their own favorites. On this point, Dr. Kennedy cannot resist releasing a broadside at a colleague who preceded him as president of the Kansas Medical Society, J. P. Root (see "Men of Their Time," KANSAS MEDICINE, Vol. 88, No. 1). Dr. Root, appointed by President Grant to be Minister Plenipotentiary to Chile, was confronted with an epidemic of smallpox which he himself contracted and described in considerable detail as to its clinical course. He gained that country's appreciation for his efforts in its behalf and felt qualified to report his own specific: alternate doses of iron muriate and prepared chalk. Chloride of lime resulted and this he proclaimed (and Dr. Kennedy scorned) as *the* treatment.

Dr. Kennedy couldn't pass up the opportunity in his presentation to damn with heavy sarcasm: "Only a few days ago," he reports, "the glad tidings of great joy were published to the world by a member of this society, Dr. J. P. Root, United States Minister to Chili (sic), South America, that he had discovered a certain specific for small-pox." Dr. Kennedy notes he simply "... convert(s) the stomach of the patient into a crucible for the manufacture of chloride of lime." He points out that it is well known that chloride of lime fails to destroy the infection of variola and Dr. Root's recovery simply points out that he had a simple, non-malignant form of the disease. Moreover, he says, since boiling water destroys the smallpox infection, why not fall back on *this*?

Whether Dr. Root was aware of this denunciation is not known. Although he returned to the States sometime in 1873, he was not at the meeting to hear it nor was he at the 1874 meeting. He did, at any rate, return to Wyandotte, practicing some time during Dr. Kennedy's tenure in office, later returning to New York State to practice, and no crossing of the paths of the two is recorded.

Dr. Kennedy might be surprised — and perhaps pleased, considering his dedication to the cause of vaccination — to learn that when that next century did bring a victory over smallpox a specific remedy was never identified and it was, after all, worldwide immunization that accomplished the task.





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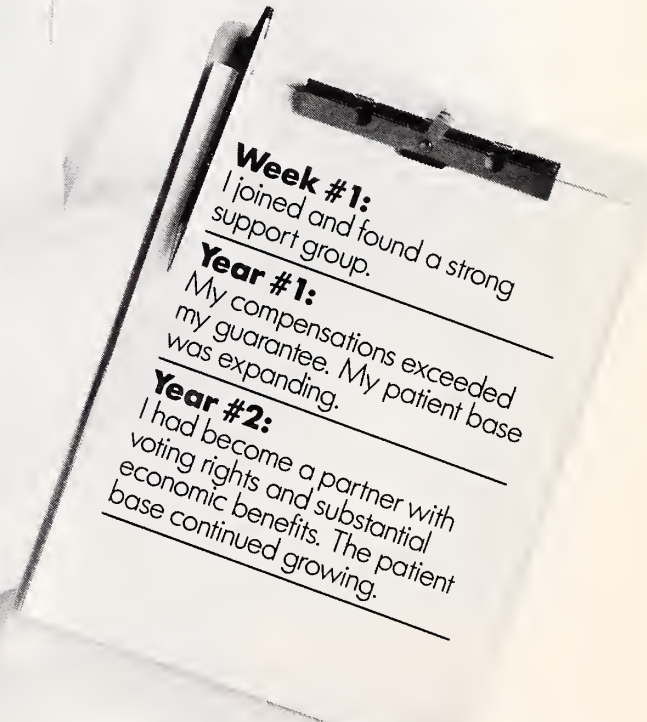
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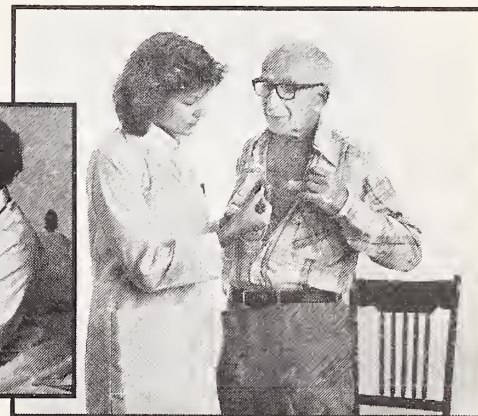
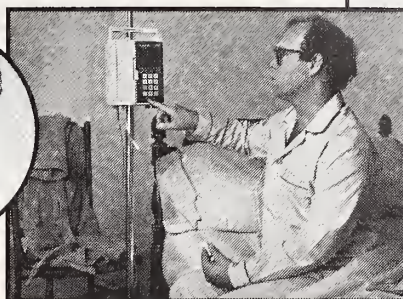
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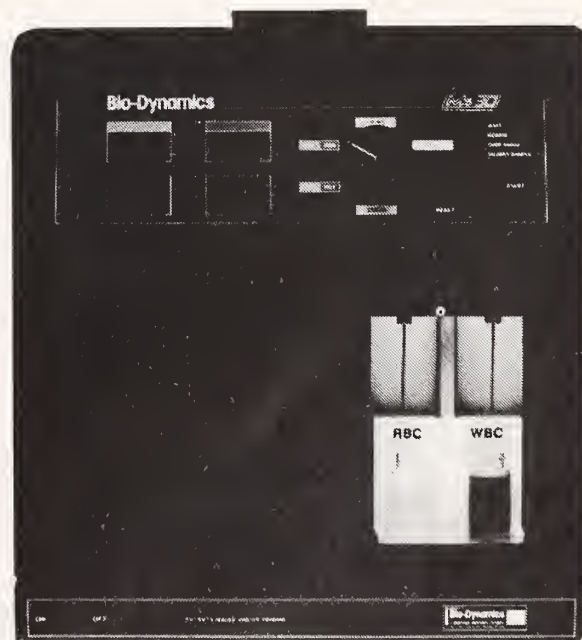
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AUXILIARY NEWS

I find the great thing in this world is not so much where we stand, as in what direction we are moving.

— Oliver Wendell Holmes

As KMSA President for 1987-88, I want to let you know where we are going. This year the theme is "KMSA — Teaching Leaders of Tomorrow." Our emphasis will be three-fold: leadership training; membership; and physician marriage enhancement.

Leadership: Leadership training will take place in workshops at our Fall Conference in Garden City in September. These workshops will provide training for officers in county Auxiliary organizations. We will also send six county presidents-elect to Chicago for the American Medical Association Auxiliary (AMAA) Leadership Training Conference. The Auxiliary is a good avenue for leadership training. All one has to do is show interest and be willing to work; there are many opportunities at the local, state, and national level.

Membership: Membership is necessary to carry on the Auxiliary business. Our most valuable asset is people. Doctor, does your spouse belong to the Auxiliary? You, by being a physician, make it possible for your spouse to belong to the Auxiliary. Our By-Laws specify that we are to work hand-in-hand with our medical societies to help them accomplish what needs to be done. We do many things for our physician spouses through the Auxiliary. We work on health issues in the community such as teenage pregnancy, AIDS, drugs and alcohol problems, AMA-ERF, and physical fitness. Physicians and spouses worked well together through our organizations on the important issue of malpractice legislation.

Physician Marriage Enhancement: On Wednesday, September 30, 1987, we are fortunate to have scheduled Dr. Gleam Powell to present her workshop called "Listening and Loving." This is an all-day working program which teaches a spouse special interpersonal and communications skills. These skills can be used independently or shared with the physician spouse through the use of the Spouse's Packet which includes a booklet and tape to take



home. It is designed to create emotional closeness, satisfaction, and more happiness in a marriage. Dr. Powell is a former faculty member of the University of Georgia and is a family and marriage therapist in Athens, Georgia. She developed this program after many years of research and counseling. The Southwest Kansas Medical Society thinks this program is important to the spouses of *all* Kansas physicians, so they are sponsoring it. It is their gift! *All* members of the Kansas Medical Society Auxiliary are invited.

These are some of our plans for the coming year. I hope your spouse will become an Auxilian and take part in all the neat opportunities, so that hand-in-hand, physicians and spouse can further enhance the world in which we live.

Phyllis Jean Bigler (F. Calvin)
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SCIENTIFIC ARTICLES

Urethral-Hymenal Fusion & Recurrent UTI

STEVEN KEITH LAWTON,* *Shawnee Mission*

THE FEMALE patient with a long history of recurrent cystitis, trigonitis, and/or urethritis poses a difficult challenge in urologic management. Recurrent lower urinary tract infections (UTI) are a dilemma frequently faced by the general practitioner, urologist, and gynecologist. Typically, the patient presents with a long history of urinary symptoms transiently relieved by various antibiotics.

O'Donnell, in 1959, was the first to suggest a hypothesis, operative procedure, and a high cure rate for an entity that can be a cause of recurrent lower UTI. He suggested that urethral-hymenal adhesions caused by inadequate rupture of the hymen (IRH) were a cause of recurrent cystitis.¹ In 1965, Hirschhorn termed the same entity "urethral-hymenal fusion" and suggested a new operative technique to correct this.²

Etiologies of Recurrent Cystitis

There are many causes of recurrent cystitis in women. It is often secondary to inoculation of the urethra by coliform organisms from the anal or perineal region. Clinically, this is frequently seen in young girls with poor hygiene after defecation.

Labial fusion, adhesive vulvitis, and urethral anomalies have all been documented as causes of recurrent cystitis.^{3,4} In 1984, Pompino and Hoffmann reported on anomalies of the external urethral orifice in 241 girls ages 3-14 years. They correlated anomalies of the urethral opening and configurations of the hymen with urethrovaginal reflux (UVR) as determined by micturating cystourethrograms. In their experience, UVR per se caused chronic urinary infection in one-third of the girls. In two-thirds of these girls, a catheterized urine specimen was negative. Pathological vaginal swabs in patients with UVR showed the same bacteria as those found in midstream urine specimens.³

Initial intercourse at a time when the vaginal environment contains multiple potential pathogens can,

and frequently does, result in the "honeymoon cystitis" so commonly seen. In middle-aged women, multiple attacks of cystitis may lead to chronic infection in the periurethral glands, which then serve as foci for future urinary tract infections.

Urethral-Hymenal Fusion

When the virginal hymen is ruptured during initial intercourse, the membrane usually is cleft radially in more than one quadrant. The orifice is asymmetrically ruptured so that future coitus can avoid this initial blunt trauma to the periurethral area. However, in certain cases, the hymenal ring may be incompletely ruptured during intercourse. Inadequate rupture of the hymen can occur in one of several ways:^{5,6}

1. A congenitally large introitus can permit entrance with no radial tearing, thus leaving the hymen intact.
2. Improper sexual technique.
3. Excessive pain with intercourse.
4. The hymen in some cases can have such tensile strength that it remains intact.
5. Multiple superficial radial tears can occur which will not extend deeply enough into perivaginal tissues to adequately separate the urethra from the vaginal introitus.

The inadequately opened orifice must then be widened by stretching and repeated dilation during painful and difficult coitus. The result is persistent, pathologic, perihymenal inflammation and ensuing fibrosis with cicatricial contraction. The distal urethra becomes abnormally incorporated into the scarred introital tissues creating the anatomic entity entitled "urethral-hymenal fusion" by Hirschhorn.

Due to the inadequately ruptured hymen, O'Donnell describes the patient as having a "relative urethral hypospadias" which causes the urethral meatus to duck into the vagina with intromission, traumatizing the urethra. It can be assumed that in some cases, especially in young teenagers, a small vaginal introitus must accommodate a rela-

*Medical Student

tively large penis, and a considerable amount of chafing occurs if the external meatus is drawn into the hypospadiac position. Thus, an avenue is provided for vaginal secretions to be milked into the urethra during intercourse.⁷ The sexually active female will thus precipitate bouts of recurrent cystitis/urethritis. Many of these patients suffer from recurrent episodes of vaginitis which O'Donnell believes is due to coital abrasions.

O'Donnell postulates that inflammation develops within the connective tissue of the urethrovaginal septum in women with inadequate rupture of the hymen, leading to bacterial contamination of the urethral and trigonal surfaces. The fibrotic orifice causes the penis to press unduly against the anterior vaginal wall causing progressive acute and then chronic inflammation to spread within the connective tissues to surround the urethra and trigone. This irritation can cause urinary symptoms when cultures and urinalysis are both negative. He postulates that this para-urethral inflammation alters the urinary tract mucosa reducing in some way its intrinsic antibacterial activity. With this reduction, contamination of the urethra via coitus can occur more easily. Thus, he feels that in most women with coitally induced long-standing urinary tract infections, the trigone and urethra can be ignored in the treatment, and the therapy should be surgical treatment of the inadequately ruptured hymen, and perhaps change of coital technique.⁸

Diagnosis

Inadequate rupture of the hymen should be expected in any patient with recurrent cystitis related to sexual activity. A careful history is extremely important and helpful in diagnosing urethral-hymenal fusion.

Diagnostic factors include:⁹

- Patients are usually in their sexually active years.
- The history of urinary tract symptoms and/or infection coincides with the beginning of intercourse or other form of mechanical sexual stimulation.
- Usually the patient has a history of classical honeymoon cystitis with defloration.
- Patients will often admit to external urethral meatus burning or "stinging" on urination after intercourse, usually several days before the flagrant symptoms of acute urethritis and cystitis begin.
- Dyspareunia of varying degrees may exist.
- Patients frequently will report no bleeding on first intercourse.

Physical Examination

The diagnosis of urethral-hymenal fusion is rarely made on cursory examination, and should be especially tested for as outlined by Hirschhorn in patients with a temporal relationship between sexual intercourse and recurrent attacks of lower urinary tract infections.^{6,9}

Procedure

1. Place the patient in the lithotomy position and inspect the genitalia carefully. Normally the external urethral meatus is located at least one inch superior to the introitus and separated from it by a band of soft tissue.¹⁰ The finding of a greater than average distance between the urethral meatus and the clitoris leads to the consideration of a congenital predisposition to urethral-hymenal fusion.¹¹

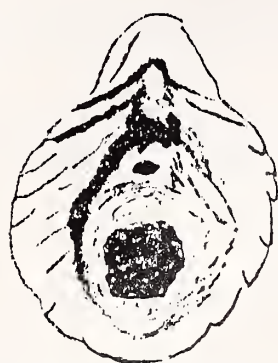
2. The hymenal ring should be stretched with one finger on either side at the nine and three o'clock positions. These tissues normally are pliable and resilient, not inelastic as in urethral-hymenal fusion. When the external urethral orifice is abnormally incorporated, the hymenal ring will sweep around and incorporate the urethral meatus.

3. By thrusting two fingers deep into the vagina and depressing the hymenal ring, the urethral meatus will be pulled abnormally inward facing the vagina and may even evert, effecting a hypospadiac position.

Figure 1 shows various hymenal configurations.

Reed, in addition to these findings, has noted a flap or hood of mucosa arising between the urethra and clitoris on stretching of the vaginal inlet as occurs in intercourse. He found a certain degree of hooding in every patient examined, but in patients with recurrent cysto-urethritis related to intercourse, the degree of hooding was particularly severe and extremely obvious. Reed postulates that during withdrawal in intercourse, this hood of mucosa scrapes vaginal secretions off the dorsal surface of the penis. When the penis is moved back in, this secretion trapped under the hood is then pushed into the urethra by the pressure of the penis. If repeated often enough, vaginal secretion can be milked into the urethra, reach the bladder, and produce symptoms of acute cystitis and/or urethritis 48-72 hours later. If urethral-hymenal fusion with relative hypospadias is not present, the urethra may not be pulled down to the vaginal opening, and the sequence of events may not occur even with hooding of the urethra.¹²

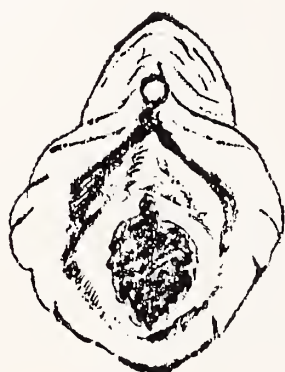
Reed advocates incision of the hood along with O'Donnell's radical hymenectomy and Hirsch-



Normal Virginal Hymen



Normal Post-coital Hymen



Urethral-Hymenal Fusion



Urethral Hood with
Urethral-Hymenal Fusion

Figure 1. Various Hymenal Configurations

horn's urethroplasty. Such a procedure was done in 92 women with complete and permanent relief of lower urinary tract infections and urinary symptoms. The longest followup was three years.¹²

Operative Procedures

The O'Donnell procedure consists of two ventrolateral incisions made through the fibrous hymenal base at the ten and two o'clock positions. A figure-of-eight stitch is placed at each apex for hemostasis and closures are made bilaterally. The remaining ventrolateral hymenal tissue is trimmed flush. For patients with urinary symptoms, the hood is divided by snipping through a few millimeters of the ventral urethra and up approximately 1.5 centimeters through the skin of the vestibular hood. The vertical incision is closed transversely. As a result, the hood will usually have disappeared.

To complete the procedure, O'Donnell increases

dorsal capacity by performing bilateral small episiotomies and excising the intervening hymenal bridge, including the hymenal base, and closing with vertical mattress sutures. O'Donnell then and since has claimed outstanding success in terms of relief of urinary symptoms and dyspareunia.^{1, 16-19}

O'Donnell reported initially on 150 cases of hymenectomies for dyspareunia, vaginitis, and lower urinary tract infections. Eighty-four per cent of these patients responded to a questionnaire six months postoperatively. All have claimed marked improvement in their symptoms. Twenty-two of these patients had had long-standing recurrent urinary symptoms. Twelve reported 100% improvement, and 19 of 20 reported greater-than or equal to 80% improvement.¹

O'Donnell¹ believes less extensive prophylactic surgical treatment will sometimes be curative: "When *early* post-marital examination of an ado-

lescent woman, truly virginal at marriage, reveals inadequate hymenal rupture, multiple radial clipping and broad forceful dilatation of the introitus is sometimes enough to destroy the hymen." He feels that any procedure which dilates the orifice yet preserves the hymen is worthless: "Once inadequate rupture is established, less than radical treatment can rarely help and may harm."

Hirschhorn's procedure has two steps. In step one, a transverse incision is made between the urethra and vagina. Dissection is carried deeply in the transverse plane 1.5 inches wide and one inch deep. Vertical suturing of the horizontal incision transposes the urethral meatus to its normal position superior to the vaginal wall. In step two, a hymenotomy is then carried out at the ten and two o'clock positions. Posterior hymenotomies are not performed.

During a period of two years, Alexander *et al* performed 28 simple hymenotomies in two quadrants as a treatment for urethral-hymenal fusion. Eighteen patients were followed long enough to be included in the study and were divided into two groups. Group I consisted of patients whose infections were definitely related to sexual activity and who had urethral-hymenal fusion. Group II consisted of patients whose symptoms were not related to coital activity, but who had prominent urethral-hymenal fusion. The success rate in patients whose symptoms were related to coitus was 85%, whereas in patients whose symptoms were not related to coitus, the success rate was only 20%. In addition, results were better in patients whose symptoms were of shorter duration; this may be because long-term infection extends to the periurethral glands which then serve as a focus for ongoing infection. They felt the data indicated that simple hymenotomy was adequate for patients with urethral-hymenal fusion and recurrent cystitis related to sexual activity, but inadequate for Group II patients. More radical procedures (*e.g.* Hirschhorn or O'Donnell procedures) in their opinion should be reserved for patients who fail to respond to this simple hymenotomy. Early surgical release of the hymen was found to produce significantly better results than if surgical repair was delayed.⁵

Case Report

A 25-year-old white female was admitted to the University of Kansas Medical Center with a chief complaint of galactorrhea of two months duration. The admission history and physical revealed that the patient had a long history of countless urinary

tract infections characterized by urethral burning, frequency and nocturia; onset coincided with her marriage at the age of 18 years. The patient complained of dyspareunia during her entire marital life as well. This patient had been seen numerous times by other physicians and had had multiple cystoscopic examinations. Recently, she had a bout of intermittent dysuria and was taking Pyridium. She reported a history of treatment with multiple antibiotics as well as Pyridium during her marriage.

On physical examination, the patient was found to have an incompletely ruptured hymen with urethral-hymenal fusion. The patient's workup for galactorrhea was inconclusive. She was given a discharge diagnosis of idiopathic galactorrhea. Surgical repair was recommended to prevent the recurrent bouts of cystitis/urethritis.

The patient was readmitted in two weeks for surgical correction of her urethral-hymenal fusion. A radical hymenectomy and urethroplasty (Hirschhorn procedure) were performed under general anesthesia.

The patient resumed coitus two months postoperatively. At her six-month postoperative followup visit, the patient indicated that she had only transient urgency shortly after surgery and had had no further urinary symptoms or dyspareunia since resuming sexual activity. When the patient was last seen in followup, 14 years later, she reported a total cure.

Summary

Recurring cystitis, chronic urethritis, and chronic infections of the lower urinary tract in women have been troublesome and vexing problems. It has been proposed that these problems can be directly related to urethral-hymenal fusion, relative hypospadias, and hooding of the urethra. For young females with urethral-hymenal fusion, the prognosis appears to be excellent when diagnosed correctly. The sooner surgical repair is done, the simpler the technique required. Some older patients with inadequately ruptured hymens and urethral-hymenal fusion who suffer from recurrent cystitis are inoperable and can be helped only by discontinuing coitus.²⁰

The practitioner confronted with the female patient who has a long history of recurrent lower urinary tract infections is urged to examine the patient for urethral-hymenal fusion. Surgical repair should be considered because of the past beneficial results for a large percentage of women.^{1, 7, 12}

References are available from William J. Cameron, M.D., Department of Obstetrics & Gynecology, UKSM-KC, 39th & Rainbow Blvd., Kansas City KS 66103. →

Mortality of Elective Abdominal Aortic Surgery in Octogenarians

ALEX D. AMMAR, M.D.,* *Wichita*

WITH IMPROVING medical care, the United States population has been steadily growing older. Because of this trend, more and more elderly patients are presenting with problems (abdominal aortic aneurysms and aorto-femoral occlusive disease) that require major abdominal aortic operation. Many physicians are skeptical about recommending major surgery to these patients (especially those over 80) because of their fears of an unacceptably high risk of morbidity and mortality. Consequently, this retrospective study was undertaken to determine the in-hospital morbidity and mortality in octogenarians who undergo elective abdominal aortic operations.

Materials

The hospital records of 64 patients, ages 80 to 92 years, who underwent elective abdominal aortic operations, were retrospectively reviewed. These patients had been referred to a large surgical group practice in Wichita from January 1, 1976 through December 31, 1985. Forty-five patients had abdominal aortic aneurysms (all greater than 5 cm in diameter), and 19 presented with varying degrees of lower extremity ischemia (four with claudication, seven with rest pain, and eight with non-healing foot ulceration or gangrenous toe). Thirteen patients were diabetic, 38 hypertensive, 28 had EKG evidence of old myocardial infarction, 51 either continued to smoke or had previously smoked with varying degrees of chronic obstructive pulmonary disease, nine patients showed slight elevations of serum creatinine (2.5 or less), two patients had old strokes, and 12 had previous coronary artery by-

pass. Current operations consisted of tube graft replacement or aorto-iliac bypass for infrarenal abdominal aortic aneurysms or aorto-femoral bypass for occlusive disease. The charts were specifically reviewed for significant morbidity, hospital stay, and in-hospital mortality. Significant morbidity included one patient with myocardial infarction, two with congestive heart failure and pulmonary edema, one with stroke, one with pneumonia, one with deep venous thrombosis, one with urinary tract infection with septicemia, and one with acute renal failure. The average hospital stay was 15.8 days, and the in-hospital mortality rate was 7.8%. Of the five deaths, three were due to myocardial infarction, one to pulmonary embolus, and one to pancreatitis.

Discussion

The question of major surgical intervention in the elderly can be difficult to answer. Many of these patients have associated medical illness and, furthermore, familial, societal, and philosophical concerns must often be addressed. Nevertheless, results of our review of morbidity, hospital stay, and in-hospital mortality in octogenarians undergoing elective abdominal aortic surgery seem acceptable and are similar to those of Diehl *et al.*¹ In reasonable risk patients, with present day methods in anesthetic and surgical care and support from the medical specialties (pulmonary, cardiology, nephrology), elective abdominal aortic surgery for aneurysmal and occlusive vascular disease certainly offers results superior to emergency aneurysm repair or major amputation. Therefore, major vascular surgery should not be withheld on the basis of age alone.

References

1. Diehl JT *et al*: Complications of abdominal aortic reconstruction: An analysis of perioperative risk factors in 557 patients. *Ann Surg* 197:49-56, 1983.

* Clinical Assistant Professor, Department of Surgery, The University of Kansas School of Medicine-Wichita.

Address reprint requests to Dr. Ammar, 818 No. Emporia, Suite 200, Wichita KS 67214.



Graduate Followup of UKSM-KC Family Practice Residency Training

JAMES G. PRICE, M.D. and BRUCE S. LIESE, Ph.D., *Kansas City, Kansas*

THE UNIVERSITY of Kansas Medical Center is a state tax supported institution and is a major site for the education of family physicians for the state of Kansas. As such, it has a vital interest in helping to maintain a supply of family physicians commensurate with the needs of the state. To accomplish this, information about graduates of the program is important, and this survey was conducted to elicit the needed data.

The goals of this survey were twofold. The first was to generate a broad profile of graduates, with the belief that information concerning the size of community selected for practice, the number of times they have moved, the satisfaction of the graduate with practice activities, spousal attitudes, and sources of continuing medical education would be useful to the parent program and to state planning agencies. In addition inquiries were made concerning practice activities.

The second goal was to assess the relationships between several important variables in the lives and practices of these physicians. It was also believed that the survey might demonstrate changes in practice patterns over the period during which the residents graduated (1975-1985), due to the rapidly changing socio-economic forces in existence during this time.

The Family Practice Program

Resident training has been the major activity of the clinical and academic Department of Family Practice since it was founded in 1971. The program is university sponsored and based. About 50% of the residency program curriculum is conducted within the medical center complex, with the remainder being in nearby community hospitals. Initially a 12-resident program (4-4-4), it expanded rapidly, and for the last nine years has been a 36-resident program (12-12-12).

From the Department of Family Practice, The University of Kansas School of Medicine-Kansas City.

Address reprint requests to Dr. Price, Professor and Chairman, Department of Family Practice, UKSM-KC, 39th & Rainbow Blvd., Kansas City KS 66103.

Methods

A survey document was sent to all (105) graduates (17.1% female) of the University of Kansas Medical Center Family Practice Residency program. Seventy-seven responses were received (90% response rate). The questions of the instrument could be answered by indicating "Yes" or "No" or by the insertion of a single word or number. The name of the respondent did not appear on the questionnaire.

Telephone followup contacts were not conducted, as had been done in other surveys.^{1, 2}

Respondents were assured of confidentiality because many of the questions were of a personal nature. Each questionnaire was numbered, with the key in the possession of an individual who did not have access to the returns. Faculty of the residency program (except for the authors who have not had access to the key) have not seen any of the returns.

Results

Characteristics of Graduates

The characteristics of the Family Practice graduates are presented according to four dimensions: professional activities; financial data; practice load;

TABLE I
PROFESSIONAL ACTIVITIES OF THE FAMILY
PRACTICE GRADUATES

Activity	% "Yes" Responses
Actively practicing Family Medicine	96
Performing obstetrics	65
First assist for FP's patient surgery	59
Type of practice	
Solo	20
Partnership	24
Group	56
Satisfied with hospital privileges	91
ABFP Certified	97
HMO Provider	66
Teaching students/residents	49
Feeling "busy enough" in practice	77

TABLE II
FINANCIAL INFORMATION ABOUT FAMILY
PRACTICE GRADUATES

Variable	Mean
Gross Income	\$132,540
Net Income	70,455
Total Indebtedness	83,122
Malpractice Premium	7,203
Variable	% "Yes" Responses
Have educational debt	58
Have retirement plan	71
Have IRA account	83
Have Keogh plan	43
Moonlight to supplement income	32
Non-medical income >\$5000/year	12
Believe too many FPs in area	12
Have practice corporation	25

and personal information. *Table I* provides descriptive statistics for professional activities of the Family Practice graduates. "Performance" of specific activities was asked rather than "possession of privileges" to perform the activity. It was assumed that performance denotes the privilege, and that the possession of a specific privilege may not denote performance of it.

In *Table II*, financial information about Family Practice graduates is presented. Included are data from the most recently graduated class which at the time of the survey had a maximum of only five months of practice. Interestingly, deletion of this class from the calculations makes very little difference in the means of gross and net incomes.

Table III presents workload data of the Family Practice graduates. The wide range of reported inpatient loads leads to the large standard deviation in this parameter. Office patient volume was obtained by queries about the average number of patients seen in the office each day rather than per week since practicing physicians are more likely to quantify their practices in this fashion.

TABLE III
WORKLOAD OF THE FAMILY PRACTICE
GRADUATE

Variable	Mean
Hours worked per week	54.75
Daily office patient load	25.19
Usual inpatient load/day	6.40

In *Table IV*, "personal information" about graduates is presented; "personal" is defined as family information (children supported, spouse satisfaction, divorces, regret at having chosen family practice, etc.).

The ways in which the graduates obtain continuing medical education were asked. It was clear that the survey group uses home study courses for at least a third of their CME, with another third coming from local hospital meetings. State Family Practice meetings were noted as a source of CME by fewer than 10% of respondents. Fifty-nine per cent of the graduates are in practice in the state of Kansas.

Gender and F. P. Productivity

Computed t-tests suggest that female and male graduates are similar (i.e., "equal") on the following variables: net and gross income, hours worked per week, malpractice premiums paid, size of community, inpatient and outpatient loads, likelihood of performing obstetrical practice, moonlighting, teaching activities, residence in Kansas, and self-reported "busy-ness."

Differences between the sexes were as follows: 65% of males serve as first assistant in surgery compared to 27% of females; 87% of males and 60% of females report that their spouses are satisfied with life as the spouse of a family physician. Male respondents report they support 2.03 children while the corresponding report from females is 1.27.

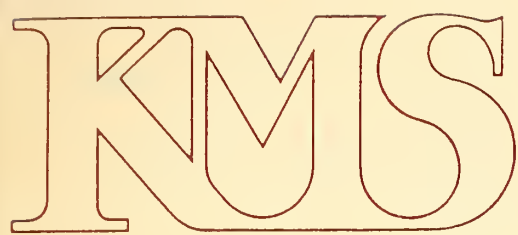
Income

The wide range of gross incomes reported was due in part to the inclusion of the 1985 graduates who had been in practice no more than five months. Utilizing median figures for gross and net incomes, overhead averaged 43% (*Table II*).

Multiple stepwise regression analysis revealed that net income was most highly related to the number of patients seen in the office each day, malpractice

TABLE IV
PERSONAL INFORMATION ABOUT FAMILY
PRACTICE GRADUATES

Variable	Total
Gender	
Male	84%
Female	16%
Regret choice of FP vocation	3%
Spouse satisfied with FP Life	83%
Divorced since graduation	9%
Current address in Kansas	59%
Number of children being supported	1.92 children



KANSAS MEDICAL SOCIETY

Newsletter

1300 Topeka Ave. • Topeka, Kansas 66612 • (913) 235-2383

MAY 1987

HOUSE OF DELEGATES ACTIONS (Details in July KANSAS MEDICINE)

Among the Resolutions adopted by the House of Delegates this month were the following:

Professional Liability--Empowered the Council and Executive Committee to take whatever action necessary to correct and overcome constitutional barriers to tort reform (87-30);

Optometry--Opposed further expansion of the optometric scope of practice (87-13 & 87-29);

Self-Prescribing--Recommended that the state legislature prohibit self-prescribing of controlled substances by physicians (87-26);

KFMC--Recommended that all physician reviewers must be members of an active medical staff (87-7);

- Endorsed KFMC for 1988 (87-7);
- Recommended limiting tenure of KFMC directors and officers (87-5);
- Endorsed onsite reviews for all hospitals and due process for physicians in reconsideration hearings (87-2);
- Supported organized medical staff participation in quality reviews (87-3);
- Recommended the use of the reporting form developed by the KMS Hospital Medical Staff Section for independent analysis of physician reviewer performance (87-4);
- Offered to assist hospital medical staffs with appropriate specialists for risk management and quality review (87-19);
- Recommended annual updates on PRO activities; and annual membership solicitation (87-7);

Peer Review--Changed the name of the Judicial Committee to the Professional Practices Review Committee (87-27);

Membership--Reaffirmed unified membership with AMA by a 99 to 32 vote (87-14);

- June 1 is the new cut-off date for non-payment of dues (87-8);
- Military Service category established for physicians on full-time active duty at 50% KMS dues (87-12);

MEET YOUR PRESIDENTS



Donald W. Hatton
Lawrence
President



Terry L. Poling
Wichita
President-Elect



Alex Scott
Junction City
1st Vice President



Roger D. Warren
Hanover
2nd Vice President

- Created Associate Membership category for oral surgeons at 50% KMS dues (87-28);

Tuition--Recommended a cap on medical school tuition until UKSM charge is equal to the average of other state-supported medical schools (87-16).

UNIFIED MEMBERSHIP RETAINED--The issue of unified membership with the AMA received much discussion in the House of Delegates. Opponents and proponents of the issue were given ample opportunity to debate the rationale for and against unification. The predominant theme struck by the proponents of unification was the need for a strong representative body at the national level. In the final analysis, the vote was an overwhelming 99 to 32 to retain unification with the AMA.



Phyllis Bigler
Garden City

The KMS Auxiliary, at their recent Annual Meeting, elected the following officers to serve during the 1987-1988 term:

President	Phyllis Bigler (Calvin), Garden City
President-Elect	Carol Loeffler (James), Wichita
First Vice President	Joan Tempero (Stephen), Topeka
Second Vice President	Linda Ellison (Paul), Salina
Recording Secretary	Lisa Barker (Stanton), Hutchinson
Treasurer	Li-Ying Lee (Song Ping), Topeka

LEGISLATIVE UPDATE

The 1987 Legislature finally adjourned the afternoon of May 4, making this session one of the longest in recent memory. The session was a fairly productive one, and the state's shaky financial situation was improved somewhat with conservative spending authorized for the coming fiscal year. A complete summary of all health-related legislation will be mailed to every KMS member shortly, but the following issues deserve mention at this time:

Optometric Scope of Practice. SB 113, the bill that expands optometrists' scope of practice, will take effect July 1. The bill authorizes the use of drugs for treatment of eye diseases by optometrists, but prohibits the treatment of glaucoma. The use of steroid-type drugs would be limited to a 14-day supply, and optometrists are also authorized to remove superficial foreign bodies from the cornea and conjunctiva.

"Exempt" License for Retired Physicians. SB 36 creates an "exempt" license which allows retired physicians to maintain their full license to practice medicine, but be exempted from the mandatory malpractice insurance and continuing medical education requirements. The bill takes effect immediately, but because of some regulatory technicalities, the Healing Arts Board will not be able to implement its provisions until a little later in the year.

Consequently, a physician who is retiring and wishes to apply for an exempt license should first apply for an "inactive" license, which then can be converted to an "exempt" license in a couple of months when the necessary regulations and forms are completed by the Board of Healing Arts. If you have any questions about this procedure, please contact the KMS office or the Board of Healing Arts.

Smoking in Public Places. HB 2412, introduced by KMS, requires that no-smoking areas be designated in every public place, including physicians offices and other health care institutions. Under this new law, all physicians must designate smoking and no-smoking areas in their offices, and post the areas accordingly. Smoking may be prohibited altogether, of course, as was the case under the prior law.

If you have any questions about the issues described above, or other legislation, please contact the KMS office.

PROFESSIONAL LIABILITY UPDATE

- Surcharge stays at 90%

Effective July 1, the surcharge on the Health Care Stabilization Fund which is added to every physician's basic premium will remain at 90% for the coming year. There had been some hope that the surcharge would be reduced, but the increasing frequency and severity of claims did not allow for a reduction this year.

- St. Paul receives 36% increase

St. Paul, which insures about 40% of the physicians in Kansas, will receive an across the board 36% increase in the premiums it charges physicians for medical malpractice insurance effective July 1. St. Paul had filed for a 65% increase, but Insurance Commissioner Fletcher Bell reduced that amount by almost half.

- Supreme Court to act on collateral source rule

At press time, the Kansas Supreme Court was about to render a decision on whether or not a key part of KMS' tort reform package was unconstitutional. The 1985 Legislature enacted a law that repealed the collateral source rule in medical malpractice cases, and lawsuits challenging the constitutionality of that change have been pending before the Supreme Court for almost six months. Although it is too early to tell, it now now appears that the court (which is dominated by appointees of former Governor John Carlin) will side with the trial lawyers and strike down this provision. Following the court's decision, the KMS Executive Committee will analyze the opinion and evaluate the options available to correct the situation.

INTEREST & FINANCE CHARGES ON YOUR BILLS

Although harsh or commercial collection practices are discouraged in the practice of medicine, a physician who has experienced problems with delinquent accounts may properly choose to request that payment be made at the time of treatment or add interest or other reasonable charges to delinquent accounts. The patient must be notified in advance of the interest or other reasonable finance or service charges by such means as the posting of a notice in the physician's waiting room, the distribution of leaflets describing the office billing practices, and appropriate notations on the billing statement. The physician must comply with state and federal laws and regulations applicable to the imposition of such charges. The AMA Council on Ethical and Judicial Affairs encourages physicians who choose to add an interest or finance charge to accounts not paid within a reasonable time to make exceptions in hardship cases.

MISPRESCRIBING & DIVERSION OF DRUGS

The AMA has developed a learning module to address misprescription of drugs and their diversion for improper purposes. The module, "Prescribing Controlled Drugs," includes a 1/2-hour videotape, a program guide, a 150-page sourcebook, and a self-test and costs \$35. Order from: AMA Dept. of Fulfillment, 535 N. Dearborn St., Chicago IL 60610; 1-800-621-8335.

VIDEO ON SUBSTANCE
ABUSE AVAILABLE

A videocassette, "Substance Abuse: Impact on the Family," is available for rent or purchase. It features information on how primary drug abuse affects not only the person who is addicted, but the family members as well. Signs of early impairment are discussed and appropriate methods of confrontation and referral recommended. To order, send check for \$10 (rental) or \$30 (purchase) to AMA Auxiliary, 535 N. Dearborn, Chicago IL 60610.

WANTED: GERIATRICIANS

The U.S. census reports that more than 5,000 people reach the age of 65 each day. Nearly half of all patients seen by general practitioners are 75 or older, and one-fourth of the drugs are sold to senior citizens. Yet the field of geriatrics, which is considered to have fewer rewards than other specialties, is attracting few students of medicine or pharmacy.

ICD-9 CODE BOOK

For information on the ICD-9 Code book, contact Commission on Professional & Hospital Activities, 1968 Green Road, Ann Arbor MI 48105; 313-769-6511.

TOPEKA BLOOD BANK
"LOOKS BACK" FOR AIDS

The Topeka Blood Bank is required to implement a "look back" procedure that will apply to past blood donations from persons who now test HIV positive with Western Blot confirmation. This is a cooperative effort among the blood bank, hospital, physician and patient, and steps are being taken to insure consent and confidentiality. The Topeka Blood Bank will notify physicians of patients who have received a blood donation that requires research and will inform him/her of the procedure. The Blood Bank will perform the tests, but blood samples must be provided through the physician's office or laboratory.

AIDS VIDEO

A videocassette, "Sex, Drugs and AIDS," is available for \$35 from the producers, ODN Productions, Suite 304, 74 Varick St., New York NY 10013. It has been recommended for audiences ages 10 years and up, and has been endorsed by the American Foundation for AIDS Research.

DEA REGISTRATION--
CHANGE IN RENEWAL
PROCEDURE

The U.S. Drug Enforcement Administration (DEA) will implement a 3-year registration period beginning in July 1987. During the transition period, some physicians will renew for one year (\$20), some for two years (\$40), and some for three years (\$60). Placement in these groups will be randomly determined. New applicants will be registered for three years. For additional information, call the DEA office in Kansas City at 816-374-2631.

MRI CONSENSUS
DEVELOPMENT CONFERENCE

An NIH Consensus Development Conference on Magnetic Resonance Imaging (MRI) will be held October 26-28, 1987, in Bethesda, Maryland. It will address the following considerations: Contraindications and risks; technological advantages and limitations (disadvantages); clinical indications; comparison with other diagnostic modalities; and directions for future research in MRI. To register or to obtain further information, contact Sharon Feldman at 301-468-6555.

Coming in August--Your new KMS Directory issue of KANSAS MEDICINE
WATCH FOR IT!

TABLE V
MEANS OF VARIABLES SIGNIFICANTLY ASSOCIATED WITH THE PRACTICE OF OBSTETRICS

Variable	OB/Non-OB	Mean	Standard Deviation
Year of graduation ²	OB	1980	2.77 yrs
	Non OB	1982	2.48 yrs
Net income ¹	OB	\$76,391	\$38,622
	Non OB	\$58,045	\$23,870
Hours worked/week ²	OB	56.6	11.13
	Non OB	49.5	10.22
Malpractice premium ³	OB	\$8,153	\$3,579
	Non OB	\$4,671	\$2,767
Inpatient load/day ²	OB	5.34	5.33
	Non OB	2.46	2.75
Total indebtedness ¹	OB	\$106,865	\$153,051
	Non OB	\$ 22,280	\$ 24,899

1. $p < .05$

2. $p < .01$

3. $p < .001$

premiums, and year of graduation. Income was not found to be significantly related to the other variables such as inpatient patient load, size of community, and type of practice.

Practice of Obstetrics

The reported practice of obstetrics was related to several variables, namely greater time in practice, higher net incomes, longer work weeks (hours), higher malpractice premiums, greater numbers of daily inpatients, and greater indebtedness (*Table V*). The practice of obstetrics had no significant relation to community size, number of patients seen per day, the number of children supported by the physician, or the gender of the physician.

Type of Practice

As to type of practice, 17 respondents reported being in solo practice; 15 in a partnership practice, and 40 in group practice. The mean number of partners reported was 16.4 while the median was four. Thus, graduates in large multispecialty groups (*e.g.* 220 partners) resulted in an exaggerated mean of group size.

An Analysis of Variance was computed to test for differences between these three types of practice. The results indicated that there were no significant differences between these types in net or gross income, hours worked per week, malpractice premium, patients seen per day, indebtedness, or size of inpatient load.

Perceived Training Deficits

Respondents were asked to list any area(s) of their training that they believed weak in preparing them for practice. Forty per cent of all respondents indicated the need for more training in ambulatory orthopedics, and 17% stated they wished they had had better preparation in practice management.

Discussion

The year of graduation from the residency was found to be related to most of the other variables which suggests that the length of time a physician has been in practice is accompanied by predictable results. Although the longer a physician has been in practice, the greater the likelihood of a higher income, it must be noted that the highest four incomes were reported by individuals who graduated since 1980.

The similarity in productivity of male and female family physicians in this survey differs from many reports in which the males were found to be somewhat more productive. Experience with UKSM-KC family practice faculty indicates that in the teaching setting, women equal or surpass men in productivity as measured by the volumes of patients seen and deliveries, as well as the total of fees charged. This is despite female faculty involvement in pregnancies, maternity leaves, and child rearing.³

The wide diversity of responses relative to weaknesses in training suggests that the character of each

TABLE VI
COMPARISON OF THE AAFP (1979)
AND THE KANSAS STUDIES (1985)

Parameter	AAFP (N = 3,021)	Kansas (N = 77)
Percent females	7.1 %	16 %
Divorced	4.6	9.3
Solo practice	23.4	20.8
No practice moves	51.5	77.3
1 practice move	33.5	17.3
2 practice moves	11.5	4.0
3 or more moves	3.1	1.3
Privilege satisfaction	96.0	90.7
Do obstetrics	64.3	65.3
Do major surgery	7.4	5.4
Surg 1st assist	62.2	59.5
Children*	1.97	1.92

*AAFP study asked for number of children "at home"; Kansas study asked for number of children "being supported."

practice, with its unique demands for specific skills and/or knowledge, helps to create perceived training deficits. Ambulatory orthopedics was the area most frequently mentioned as one for which preparation had been perceived as weak.

The largest of other similar studies reviewed was that done by the American Academy of Family Physicians in 1979,⁴ which limited the study population to 4,295 ABFP diplomates who had graduated between 1970 and 1978. Since this period represents approximately the first half of the time period covered by graduates in the Kansas study, comparisons between the two study cohorts reflects similarities between UKSM and national graduates (Table VI).

The data obtained in this survey will be utilized for several purposes, the first being calculation of appropriate size of the training program as related to Kansas' need for family physicians. The fact that payback regulations for the Kansas Medical Schol-

arship program were tightened in 1982 will undoubtedly increase the retention in the state of graduates who received Kansas Medical Scholarships. The current retention of FP graduates is 59%. The bimodal distribution of practicing family physicians now in the state⁵ indicates that during the next 10-15 years, attrition by as much as 40% may occur due to death and retirement. Since present level production of all family practice programs in the state (38 graduates each year) is less than expected attrition, reduction of program size at this time is not warranted.

Shifting of emphasis in the residency curriculum to include more ambulatory orthopedics and practice management is underway. Education of residents about HMO function is an important part of the latter.

Periodic resurveys of the graduates of this program will provide additional information regarding practice trends of family physicians in Kansas and will be helpful in the rational allocation of state resources for the production of family physicians.

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Acknowledgements

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Facing Cancer Together

A Volunteer Program for Small Communities

DAVID W. BOUDA, M.D., *Hutchinson*

MOST VOLUNTEERS in this program who will work with cancer patients have had the disease themselves, and because of their personal experiences, they are in a unique position to help others.

The program outlined here provides a volunteer support system for cancer patients at the community level, particularly for those patients who are receiving active treatment. Guidelines established by the American Cancer Society for their program known as CanSurmount were partially utilized in this program, which is an extension of an established support and education program called Facing Cancer Together. This program is an attempt to meet the special needs of cancer patients so that they can better understand and cope with their disease.

Paid hospital personnel or physician office personnel do not have the time, nor necessarily the capacity, to provide the innumerable supplemental supportive services that are not required for the patient's physical care but are essential psychologically. The cancer patient is usually fearful — fearful of being abandoned, fearful of pain, fearful of the unknown. The volunteer offers the precious gift of time, and the reassurance provided by an attentive, compassionate person is invaluable.

Common emotional effects of cancer are despair, guilt, anger, isolation, and loneliness. Patients often think that what they are feeling is unique. They may feel guilty for being angry with their doctor or their god, and family members may not know how to act or react.

Cancer patients can be very special cancer professionals. They have experienced something that most graduates of medical, nursing, and divinity schools have not. They have experienced treatment. They have experienced depression and isolation. They can understand why having your hair fall out is upsetting. They can appreciate a patient's reluctance to start on chemotherapy. They can even understand the occasional patient who chooses not to have his/her cancer treated, for they have often wondered themselves if it was and is really worth it.¹

The person with cancer may have to struggle not only with the fear of death, but with the fact that significant others refuse to discuss this fear. Four areas of concern have been identified by the participants of one support group: loneliness; grief related to physical and social losses; reactions of family and friends; and lack of specific and accurate information about living with their illness. Facing their diagnosis alone was the most frightening prospect, but they also found it difficult to share their thoughts with loved ones. They felt a need to talk to others going through similar experiences.

Common human experiences can act as a bond between the persons involved. There is authenticity in the empathy that comes from a person who has undergone the same experience. Sometimes, a volunteer may act in a way to "repay" the help s/he received or may offer services that the volunteer would have appreciated but did not receive.

Minimum requirements for initiating a volunteer program include a few dedicated people who are willing to assume appropriate responsibilities and perform essential activities, *e.g.*:

- Physician, personal or specialist, to obtain hospital clearance, to refer patients, and to provide educational programs for volunteers, patients, and professionals.
- Trained volunteer or volunteer coordinator to recruit and train volunteers, to schedule regular volunteer meetings, and to provide educational programs for volunteers, patients, and professionals.
- Hospital and clinic staff members (nurse, social worker, chaplain, American Cancer Society worker). Responsibilities include assistance with recruitment and training of volunteers, assistance to the physician for referral patients, providing educational programs for volunteers, patients and professionals, matching volunteers to patients, conducting inservices for other hospital staff, and assisting with communication between administrators and the volunteer coordinator.
- Cancer patients whose responsibilities include

TABLE I
FORMAT FOR INSERVICE SESSIONS

- A. Brief personal introductions of panel members
- B. The Facing Cancer Together program and philosophy
 1. Background information
 - a. Facing Cancer Together beginnings
 - b. Organizational structure
 2. Volunteers' profiles (age, personality, type of cancer)
 3. Volunteer visitations (what takes place)
 4. Services available and review of community resources
- C. How to request a volunteer
- D. Wrap-up
 1. The role of physician or nurses
 2. Distribution of brochures

providing moral support to patients and making patient visits on a regular basis.

Because Facing Cancer Together is partly a hospital-based program, the cooperation and support of the hospital administration, as well as that of the physician's office, is essential. Administrators must be provided with information about the programs so they will understand what will be expected of the hospital and what the benefits will be. Hospitals will benefit from this program in the following ways:

- Cancer patients and their families will receive added emotional support.
- Volunteers can provide physicians and nurses with useful information regarding individual patient needs.
- Volunteers from different walks of life can help to promote more community involvement in the hospital and create a better community image for it.

The cost of this program is minimal, but the hospital or clinic should be asked to contribute space and equipment such as identification pins for volunteers, occasional use of meeting rooms, office space, basic office supplies, and copying privileges. Financial support may come from a variety of sources, including cancer patients and their families and other private donors.

Information presented at inservice sessions should be supplemented with handouts and personal conversations. A panel discussion can effectively promote an atmosphere for sharing experiences and needs. The effectiveness of a program should be monitored by questionnaires and selected psychological tests. The need for involvement of nurses and referring physicians will be emphasized

TABLE II
PURPOSE OF INSERVICE SESSIONS

- Session I : To let trainees meet each other; to explain the philosophy of the program. Trainees are given a brief overview of the whole program.
- Session II : To familiarize the trainee with the actual volunteer work in the hospital or local physician's office.
- Session III: To explore the trainees' feelings about their work; role-playing is used to explore actual patient-volunteer encounters.

throughout the session. A brief outline of the format for inservice sessions is shown in *Table I*.

Initially, patients selected for this program should be receiving active treatment under the direction of a cancer specialist, but any individual with a diagnosis of cancer who needs a supportive relationship could be included. The most important requirement for participation is an awareness of the diagnosis of cancer on the part of the patient. Although referrals may be made by nurses, it is recommended that the volunteer coordinator receive consent for visitation from the primary physician.

Prior to the patient's discharge from the hospital, staff can acquaint the patient and his/her family with the Facing Cancer Together program by explaining its benefits and answering questions.

Possible reasons for patients' unwillingness to participate might be a fear of being identified as someone who is not coping well with the disease, misunderstanding of the purpose of the program, fear of additional financial burden, denial of the disease, and suspiciousness of health care providers.

Recruitment of volunteers should be a serious and thoughtful process. The volunteer coordinator will contact potential volunteers for an initial screening interview to be conducted in person. Individuals who show an interest and willingness to commit themselves to the program will be invited to attend the next scheduled training program.

For the purpose of defining criteria as simply as possible, only the treated cancer patient as a volunteer will be considered, although family members of cancer victims can also establish supportive relationships with cancer patients and their families, and eventually their potential for use in this program should be developed.

Cassem describes important characteristics for volunteers: The first is the capacity to be touched, to be sensitive to the needs of another person. A good volunteer must appreciate how bad things can be, but also be able to appreciate how much good

there is in people. The capacity to enjoy them and to come to know them is the second all-important ingredient.²

Other factors to consider in volunteer selection include health status and availability of time. A positive recommendation from the volunteer's own physician is mandatory. In many volunteer programs such as this one, a one-year commitment is required, and this should be considered during the selection process. The training program requires six to eight hours divided into four sessions (*Table II*).

Panel discussions on how to be helpful to the patient and his/her family in time of serious operations, grief, and loss can be helpful. Participants could include various clergy, an oncologist, a surgeon, and a nurse. Hypothetical situations are followed by a question-and-answer period. Volunteers should be helped to understand that many patients and family members who seem unfriendly are grieving and do not really intend to be abusive.

A list of DOs and DON'Ts for volunteers,³ written by a volunteer with a widow support group, has been slightly altered to focus on cancer patients:

DOs

Be yourself; act natural and don't try to be superhuman.

Listen to verbal and nonverbal communication.

Be thoughtful.

Be informed; know about available community resources.

Learn the special talents of the patient.

Be patient; allow enough time at each visit so you don't have to be a clock watcher.

Be trustworthy; keep confidential anything said or done by the patient.

Be observant; assess the emotion, education, and financial status of the patient so you will be prepared should the need for help arise.

DON'Ts

Don't be aggressive or pushy.

Don't be effusive or overly cheerful.

Don't be judgmental or critical.

Don't pry.

Don't take your own problems with you.

Don't compare progress to other patients.

Don't make decisions for the patient.

Don't allow the patient to become too dependent on you.

Don't overload your schedule; work only with those to whom you can devote ample time.

Don't be afraid to say, "I don't know," but add,

"Perhaps we can find out together."

Don't give up.

The volunteer's role must be tailored to the needs and wishes of each individual patient and family. Factors that determine the specific tasks to be performed by the volunteer include the age of the patient, the availability of natural support systems such as nuclear and extended family and friends, economic circumstances, the state of the illness, the degree of mental functioning, strengths available to the patient, and the reality pressures created for the family by the patient's illness.⁴

Caring requires volunteers to listen and observe with their whole person. The patient's chief concern determines the initial point of focus. The caring person is sensitive to what the patient wants to discuss and responds to his/her cues.

To make the initial contact, the volunteer is encouraged to write a short note to the patient, to identify the volunteer as a former cancer patient who has received treatment. It should be stated clearly that the volunteer is responding to a referral made to the Facing Cancer Together volunteer coordinator, and that there is nothing to sell and no fee involved. The letter will suggest a time when the volunteer will visit the patient. A telephone number should be included so the patient can respond and request more information about the program if desired. The letter should be written on letterhead of the Facing Cancer Together agency.

It is helpful if the physician explains the program to the patient and asks if s/he is willing to talk to someone from the group. This connects the volunteer to the team in the patient's mind.

The volunteer can also assist the patient's family. They, too, need someone to listen to their fears, to share their sense of loneliness and confusion, and to be reassured that their feelings are appropriate.

To be responsive to needs of patients and to reach out and care, the volunteer, too, needs a support system of people who care for him/her. Work with cancer patients requires great amounts of physical, emotional, and spiritual energy. To maintain a healthy perspective, the volunteer needs time to do the things s/he enjoys. It is recommended that the volunteer be assigned no more than three patients at a time, and the volunteer coordinator should exercise judgment and space assignments to allow respite time as needed.

Arrangements must be made for the volunteers to meet frequently to support and encourage one

(Continued on page 173)

Stress Management in Residency Training Programs

HERBERT R. GOLDBERG, M.D.,* *Wichita*

PHYSICIAN IMPAIRMENT due to stress has become a prominent health and social problem on a national level. The problem represents one of the consequences related to the changes, expectations, and demands in the training, teaching, and practice of medicine.

Efforts that focus on case finding and treatment represent only a portion of the issue. Attention must be given to prevention of impairment through early training efforts and intervention in the impairment situation in a prompt and precise manner.

Stress in residency training is well acknowledged. However, it is imperative that residency programs develop protocols to confront the problem of stress and impairment by focusing on methods of prevention, establishing early correction, providing emotional support, issuing clear guidelines, and by modifying environmental stressors. In a profession whose goal is to provide health and well-being, it is confusing to note that the training process can occasionally overlook the factors that contribute to the maintenance of physical and emotional health. Professional development of physicians should include training in practice behaviors and coping skills. It is important to sensitize program directors and faculty to the stress that occurs during residency training. The physical and emotional health of the resident relates to the whole question of the educational effectiveness of the programs.

Recognizing the problem of stress in Pediatric house staff training, the Department of Pediatrics at The University of Kansas School of Medicine-Wichita has developed a model project which is a part of an internal audit of the postdoctoral training program. The project includes four areas useful in management and modification of resident stress and performance.

The first area involves the development and implementation of an effective advisor system. Careful planning and execution of an advisor system with

a commitment to medical education requires a resident advocate whose function includes:

- Maintaining the operational system of the department.
- Developing teaching/learning opportunities, such as:
 - Aiding the resident with career plans;
 - Providing a role model for professional and personal development;
 - Reviewing in-service evaluations and providing feedback on performance; and
 - Initiating self-learning, self-education, and time management programs.
- Supervising and counseling which will include:
 - Acting as a confidante for ventilation of feelings;
 - Early identification of problems;
 - Initiating referral for timely provision of counseling and psychological support services; and
 - An overview of goals and objectives in carrying out patient care responsibilities.

The second area's major direction is the PL-I (Postgraduate Level Year I) tutorial program. All first-year residents are required to attend teaching sessions which meet biweekly. These sessions are arranged at a convenient, non-interrupted time to accommodate both residents and faculty. The tutorials continue throughout the PL-I year. The first sessions provide orientation to the system as well as an overview of the resident manual. Subsequent sessions deal with core curriculum topics presented in depth and taught by reviewing the general textbooks and pertinent articles from the current pediatric literature. Progress is monitored by consultation between the teaching faculty and the resident advisor at one to two month intervals. The tutorial program provides a mechanism for reduction of negative stress early in the residency program. It expands the data base of first year residents, gives guidance on learning methods, and monitors per-

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TABLE I
SURVEY INSTRUMENT USED IN UKSM-W RESIDENCY PROGRAM

*The University of Kansas School of Medicine at Wichita
Department of Pediatrics*

Pediatric House Staff Stress Level Survey

Please circle the level that applies with
1 = Not experienced, 2 = Rarely experienced, 3 = Frequently/periodically experienced,
4 = Repeatedly experienced, and 5 = Constantly experience

1. Sleep deprivation and/or fatigue	1 2 3 4 5
2. Feelings of loss of control over life	1 2 3 4 5
3. Feelings of incompetence/inadequacy	1 2 3 4 5
4. Difficulty in balancing personal and professional time	1 2 3 4 5
5. Feelings that the patient (or parent) is an "enemy"	1 2 3 4 5
6. Feelings of self-doubt	1 2 3 4 5
7. Frustrations with decisions related to marriage, family, and/or interpersonal social relationships	1 2 3 4 5
8. Experiencing "roller coaster emotions"	1 2 3 4 5
9. Reinforcement for factual knowledge but not for the complete patient care provided	1 2 3 4 5
10. Need for more nurturance by the attending staff	1 2 3 4 5
11. Sensing a lack of preparation for the "real" world of practice	1 2 3 4 5
12. Depression associated with a dying patient and grieving parents	1 2 3 4 5
13. Annoyance with attendings saying, "As house officers, we had it 'such and such' "	1 2 3 4 5
14. Concern with lack of understanding of residency distress and work in the non-medical world	1 2 3 4 5
15. Feelings of being asked to do more than realistically able	1 2 3 4 5
16. If you smoke cigarettes or drink, has frequency of use of either increased?	1 2 3 4 5

formance in a constructive and non-threatening manner. The tutorial assures improved evaluation of the knowledge, skills, and professional growth of each PL-I resident in the training program.

The third area is assessment. The "Pediatric House Staff Stress Level Survey" was administered in the third month of the training year to all residents (PL-I, PL-II, PL-III). This is to be an ongoing program. The survey remained anonymous in order for the department to determine and evaluate the overall stress level as compared to other administrations of this instrument throughout the residency program.

The survey instrument is presented in *Table I*. This survey can be used as an initial evaluation survey early in the academic year and can be repeated in six months for comparison. It has been useful to correlate the results with resident performance. The survey also provides a baseline for future intervention and development of more comprehensive residency stress management programs.

The fourth area is an extension of the surveying mechanism. It offers a thorough introduction on coping skills for residents. The coping skills program is designed to assist resident physicians in

becoming aware of stress and its effect in their personal lives, professional performance, and in understanding how their own stress affects their interaction with patients.

The coping skills program consists of six, one-hour group sessions. The initial stage of the program consists of a self-assessment using ESSI Systems Stress Mapsm, a comprehensive self-scoring, stress assessment tool. In future sessions, the results of this evaluation can be used to design individual improvement plans and provide the basis for group discussions. The program modules are designed to increase understanding of stress and coping mechanisms, balancing pressures and satisfactions, building self-care and relaxation skills, understanding self-management options, increasing interpersonal skills, and enhancing professional strength in an effort to avoid burnout and impairment.

The program is intended to give individual residents improved coping skills so as to deal with the inevitable environmental stressors. It is designed to be facilitated by a behavioral science faculty member and is conducted over several months by means of weekly meetings.

(Continued on page 169)

PRESIDENT'S MESSAGE

As your newly installed President, I want you to know that I am proud of the Kansas Medical Society. The Society often has been first in new and innovative ideas. One example has been the model of an alternative compensation system for professional liability claims, an idea that is now gaining support throughout the federation of medicine. I am certain that the delegates and leadership of the Society will continue in that same tradition. The Society is not one to sit still and simply be satisfied with the *status quo*.

I think that the Society's vote to be unified with the AMA is an example of that desire to be involved. As Dr. Reals has written (KANSAS MEDICINE, April 1987), "If not the AMA, then who?" It is my belief that the AMA does need our support. We do need an umbrella organization. Yes, I fully understand that each of us has his/her own niche in this medical world and that we each have those special societies to which we feel a greater allegiance than the AMA, and possibly even the Kansas Medical Society. I foster and encourage these involvements in specialty societies so they, too, can be more representative.

The Kansas Medical Society and the AMA are grassroots, representative organizations that have a unique place in the medical political arena. We as physicians have to be involved. We cannot be *laissez-faire* concerning the political happenings in the United States at this time. The *status quo* in medicine will not remain if we ignore politics.

The political mood in Washington is one of change and one of intrusion into the doctor-patient relationship. We as physicians have to counter by thinking of new, innovative ways to affect the legislative process. We need to be certain that what occurs legislatively will not harm quality or access to medical care in the United States. Your specialty makes little difference. We each must be aware and concerned about this intrusion.

I think there are ways that we can enhance the quality of care, provide improved access, and control the costs in a way that will be satisfactory for both patients and physicians. Legislators need help to come up with better ideas. We as physicians, since we understand the medical world better, should



be able to do that. We as physicians have to be involved to provide the information and the guidance.

The Kansas Medical Society represents a large portion of the Kansas physicians. It will not sit on the sidelines. We never have and we never will. The medical society will progress, it will innovate and it will help the cause of the patient-physician relationship. In Colorado two years ago, the delegates felt that the AMA was a way in which we could innovate, and could help that relationship. What will come in the future year, I do not know — only the delegates can dictate. For this reason again, I encourage you to be involved. Because without you we are less, and if we are less we may only be able to sit on the sidelines and watch.

A handwritten signature in black ink, reading "Donald V. Hatten" followed by a stylized monogram.

President

EDITORIAL COMMENT

Spreading the Word

PHYSICIANS ARE more often than not a dissentious lot but probably come as close as possible to unanimity on one point: they are inundated with far more printed material than they can digest. Our professional involvement cringes at the idea but our personal experience supports it. In the area of communications to the public certainly, there is no doubt that overabundance is the word.

In recent years, however, the American Medical Writers Association has collected individuals of that ilk and fostered standards and training that permit them to maintain a reasonable balance in an easily unbalanced area. The problems of these conscientious people have been delineated by one of their respected members, Elizabeth M. Whelan, Director of the American Council of Science and Health. Lay communicators are faced with a public that often wants entertainment rather than information or, ambivalently, is drawn by fears that are engendered by the plethora of "risks" that appears at every turn. Healthy or morbid the interest, it seeks a reassurance of safety — immediate or at least imminent — rather than the stress of information that must be rationally analyzed.

This ambivalence in the lay attitude is known to every physician through a variety of patients — if not compounded within one patient. Unreasonable expectations combine with fears — fears of diagnosis, of treatment (or lack of it), or of prognosis. But the role of the physician is different and care must be given in the handling of individual patients in a manner not incumbent on writers whose efforts (although they may be measured in public response) are detached from that public as individuals. The latter, in fact, often turn to their physicians for clarification and reassurance. So the lay writers may "treat" the public and assure that more "patients" will be produced.

Thus, as dedication to medical communication grows, the conclusion that these communicators are faced with an audience that wants entertainment or, rather, information on an entertainment level, becomes more valid. It is apparent from Ms Whelan's presentation, however, that her profession recognizes the very problems for which we have at times

criticized its members — problems that are different for physicians. They are subject to pressures of promotional demands, their own for individual accomplishment or those of their sponsors (a pressure some physicians have resolved by promoting themselves). Writers, within their own ranks, encompass widely ranging philosophies and loyalties, again their own or their sponsors'. Although physicians have been just as eclectic in their personal attitudes, they too may find, as physician employment in various medical ventures grows, that corporate philosophies must be accommodated.

The market place, rapidly becoming a greater dictator of physician activity, still affects the writers' efforts more strongly since the latter form the bridge from medical activity to the public — *as* the public. Individual physicians' communications at whatever level are subject to skepticism by that public because of their source while the professional communicators efforts have the more immediate appeal, being more readily accessible and posing as entertainment. Their reports begin and fertilize the public mind while physicians, by tradition and by the restraint of experience, are necessarily slower on the draw.

Those purveyors of reports to the laity maintain their effectiveness by their ability to project themselves as knowledgeable, sincere and in command of the situation, a luxury not generally available to physicians. Their direct personal involvement with their public (that is, patients) requires that efforts must be directed toward assuring that those patients assimilate the information and are not beguiled by the entertainment. The problems of both, then, have much in common generally and many differences in detail.

The total relationship has many more facets but stimulated by the consumer age, a mutual interdependence, formerly unknown, has developed. Lay communicators have an awesome responsibility to recognize and keep in perspective the sources of their information and impact of their communications. Physicians have a responsibility to provide objective support. The public, individually and collectively, is the beneficiary. — D.E.G.



Antitrust Immunity for Reviewers

WAYNE T. STRATTON, J.D.,* *Topeka*

A NEW FEDERAL law offers the possibility of increased protection to the peer review process but is not without increased burdens and potential problems.

What is labeled the Health Care Quality Improvement Act of 1986 was signed into law by President Reagan on November 14, 1986. It is intended to provide immunity from antitrust claims to participants in the peer review process. However, it goes far beyond that by imposing reporting obligations upon hospitals and by establishing a national clearing house of information on physicians and dentists.

The new act chiefly provides immunity from claims under the federal antitrust laws, provided that various due process requirements are met. Among those are a requirement for a specified form of notice of proposed action with regard to a physician who is the subject of a peer review proceeding and a specified form of a notice of hearing. The notice of proposed action must contain the reasons for the proposed action and also provide various items of information with regard to a hearing. The notice of hearing must include a list of the witnesses who are expected to testify at the hearing.

In addition, the new law contains specific rules as to how the hearing must be conducted. Of note is that the hearing panel or hearing officer must be "not in direct economic competition with the physician involved" in the hearing. The legislative history of the act indicates that Congress was specifically aware of the problem that new requirement would present in rural areas and in particular spe-



cialties. However, in the view of Congress, the peer review process is expected "to make every reasonable effort to find appropriate officers or members of the panel, even if this requires bringing reviewers from out of town or using physicians of a different specialty." Because of that new law and also because of the new risk management provisions contained in House Bill 2661 passed by the 1986 Kansas legislature, physicians may anticipate that some hospitals will contract with outside organizations to provide peer review involving physician privileges.

The new act also requires that states establish a reporting system similar to that already in place in Kansas. In addition to requiring that hospitals report actions relating to a physician's clinical privileges, the new act also will require professional societies to report actions that affect the membership of a physician if that action is based upon competence or professional conduct. Under the new law, the report is to be made to the state licensure board and by it to a national clearing house.

That national clearing house, when it is established, will also acquire information on all payments

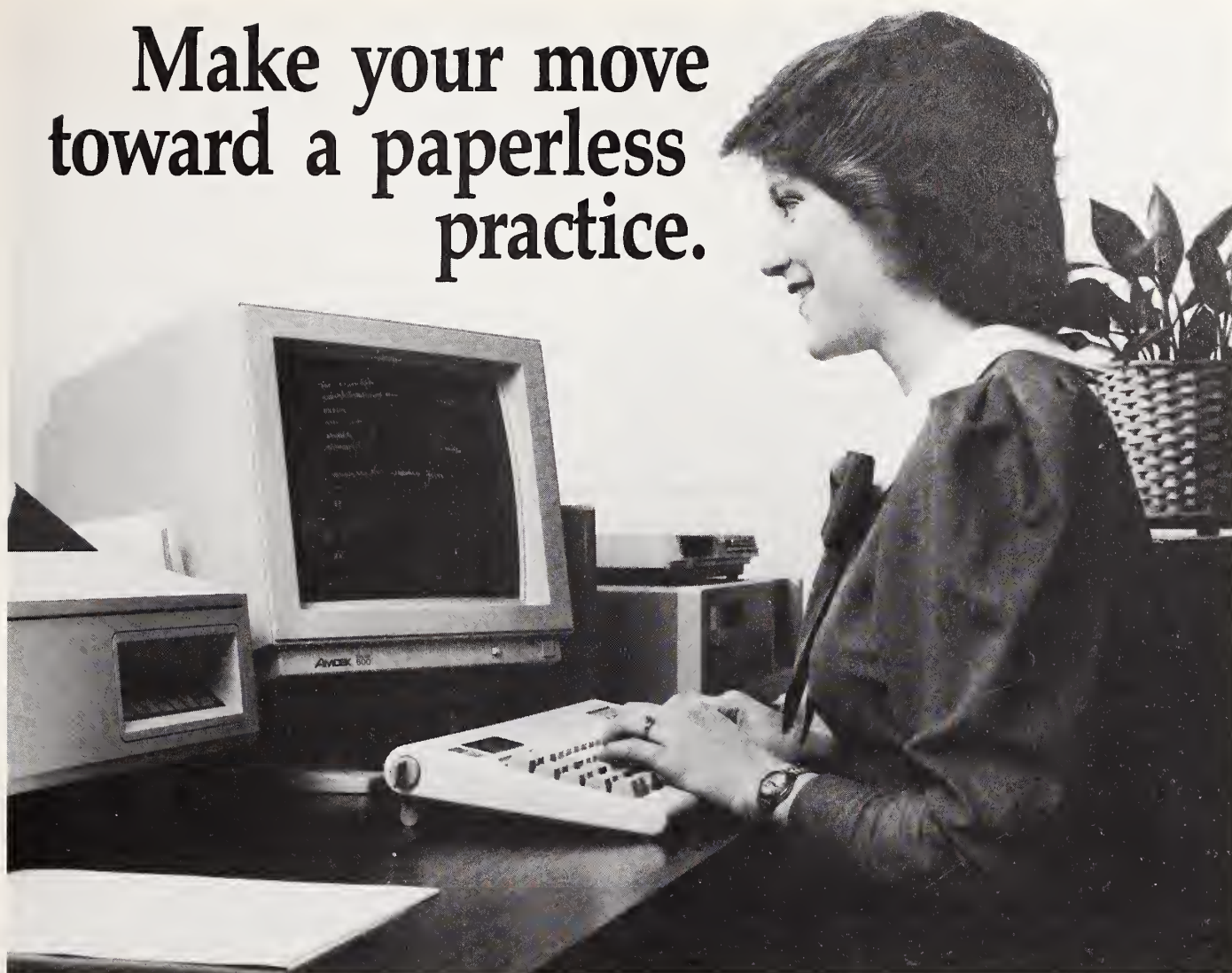
* KMS Legal Counsel.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE or the Kansas Medical Society. For further information, contact Mr. Stratton, 215 E. 8th, Topeka KS 66603, 1-800-332-0248.

(Continued on page 168)

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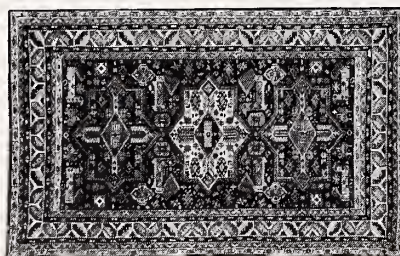
(Continued from page 166)

made in settlement or in satisfaction of a judgment in a medical malpractice case. The information to be reported by insurance companies under the new requirement will include the physician's name, the amount of the payment, the physician's hospital affiliation, and a description of the facts of the case. Any insurance company that fails to report information may be subjected to a civil penalty of up to \$10,000 per omission.

The new act does not specifically require that hospitals or professional societies comply with its various requirements as to the structure of a peer review hearing. Such compliance is necessary only if the hospital and participants in the peer review process wish to obtain the protection of the immunity from the antitrust laws that it offers. Until such time as the immunity provisions in House Bill 2661 are applied and interpreted by courts, the protections provided under the federal law offer additional peace of mind. Therefore, physicians should seriously consider amendments to medical staff by-laws to comply with the specific due process requirements in the new federal law.



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- Tablet dosage form may be appreciated by patients of all ages

NEW Keflet Tablets are available as:

250-mg
Tablets



500-mg
Tablets

Keflet is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-sensitive patients.

Brief Summary. Consult the package literature for prescribing information.
Indications and Usage: KefletTM Tablets (cephalexin, Dista) are indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Respiratory tract infections caused by *Streptococcus pneumoniae* and group A β hemolytic streptococci (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. Keflet is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of Keflet in the subsequent prevention of rheumatic fever are not available at present.)

Otitis media due to *S pneumoniae*, *Haemophilus influenzae*, staphylococci, streptococci, and *Neisseria catarrhalis*

Skin and skin structure infections caused by staphylococci and/or streptococci

Bone infections caused by staphylococci and/or *Proteus mirabilis*

Genitourinary tract infections, including acute prostatitis, caused by

Escherichia coli, *P mirabilis*, and *Klebsiella* sp.

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

Contraindication: Keflet is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflet.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile*. Other causes of colitis should be ruled out.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Precautions: *General*—Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflet occurs, the drug should be discontinued and the patient treated with the usual agents (eg, epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflet may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Keflet should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflet, a false positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest[®] tablets but not with Tes Tape[®] (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—*Pregnancy Category B*—The daily oral administration of cephalexin to rats in doses of 250 or 500 mg/kg prior to and during pregnancy, or to rats and mice during the period of organogenesis only, had no adverse effect on fertility, fetal viability, fetal weight, or litter size. Note that the safety of cephalexin during pregnancy in humans has not been established.

Cephalexin showed no enhanced toxicity in weanling and newborn rats as compared with adult animals. Nevertheless, because the studies in humans cannot rule out the possibility of harm, Keflet should be used during pregnancy only if clearly needed.

Nursing Mothers—The excretion of cephalexin in the milk increased up to 4 hours after a 500-mg dose; the drug reached a maximum level of 4 µg/mL, then decreased gradually, and had disappeared 8 hours after administration. Caution should be exercised when Keflet is administered to a nursing woman.

Adverse Reactions: *Gastrointestinal*—Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely. The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Dyspepsia and abdominal pain have also occurred. As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

Hypersensitivity—Allergic reactions in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson Syndrome, or toxic epidermal necrolysis have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Eosinophilia, neutropenia, thrombocytopenia, and slight elevations in SGOT and SGPT have been reported.

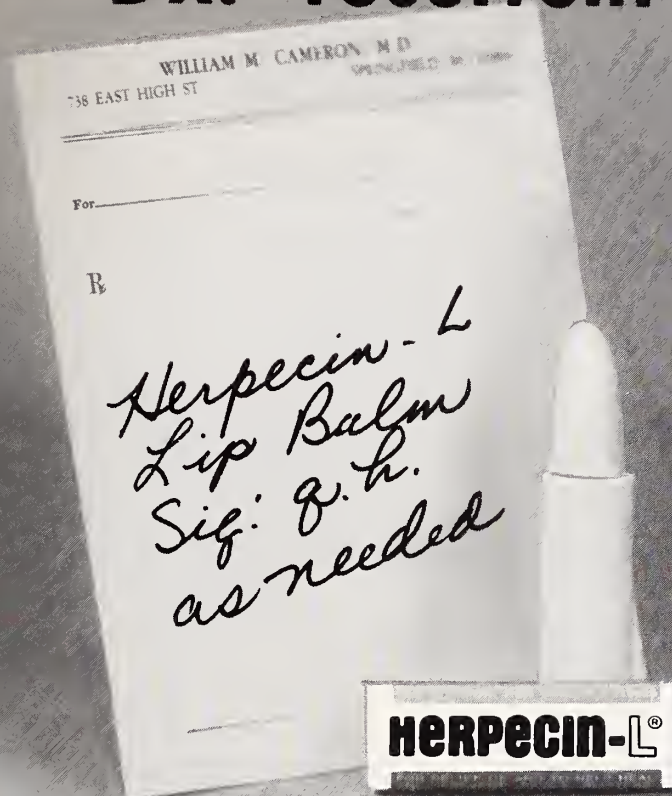
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In Kansas HERPECIN-L is available at all Osco, Revco and Wal-Mart and other select pharmacies.

Stress Management

(Continued from page 163)

Summary

A program has been developed by the Department of Pediatrics of The University of Kansas School of Medicine-Wichita which centers on a four-part approach to the management of stress in pediatric house staff training. The overall program includes structuring an effective advisor system, a PL-I tutorial program, a house staff stress level survey, and a comprehensive course on coping skills for residents. It is hoped this project can assist other res-

idency programs in developing similar programs that address their individual needs. Through this approach residents may be scrutinized for signs of stress. This information can guide the faculty in supporting residents before they become severely stressed. At times, it may be appropriate to adjust schedules and to look for other methods to reduce stress without compromising quality training. Residency training and education should be based upon knowledge and skills acquisition without the health professional losing his or her own health in the process.

A bibliography is available from Dr. Goldberg, USKM-W, 1010 No. Kansas, Wichita KS 67214.



Continuing Medical Education

The 1976 Kansas Legislature enacted a law requiring continuing medical education as a requisite to relicensure in Kansas. HB-2723 provides that, "From and after July 1, 1978, the Kansas State Board of Healing Arts shall require every licensee to submit with the renewal application evidence of satisfactory completion of a program of continuing education required by the Board." Physicians not in the active practice of the healing arts in the State of Kansas may be exempted from the continuing medical education requirements for relicensure by signing an affidavit furnished by the Kansas State Board of Healing Arts. The following is a description of the CME requirements established by the Board, and an explanation of how to comply with the requirements.

As a basic requirement, the Board adopted the CME requirements of the Kansas Medical Society, which is the attainment of the American Medical Association "Physician's Recognition Award." The basic criterion for the PRA is 150 hours of educational experience over a three-year period. The educational activities are described in six separate categories. Below is a brief description of each category and the maximum number of hours that can be obtained in each category:

	<i>Credit Hours Limit</i>
Category 1 — CME activities with accredited sponsorship (60 hours required)	no limit
Category 2 — CME activities with non-accredited sponsorship	90 hrs.

Completion of AMA-PRA satisfies the requirement established by the Board. Because relicensure is on a yearly basis, and the PRA is on a three-year basis, a physician need only have a valid PRA in effect to be in compliance with the requirements of the Board.

Additionally, completion of the CME certification programs of any of the following organizations also constitutes compliance with the requirements of the Board:

- American Academy of Dermatology (AAD)
- American Academy of Family Physicians (AAFP)
- American Association of Neurological Surgeons/
Congress of Neurological Surgeons (AANS/CNS)
- American College of Obstetricians & Gynecologists (ACOG)
- American College of Preventive Medicine (ACPM)
- American Psychiatric Association (APA)
- American Society of Clinical Pathologists/
College of American Pathologists (ASCP/CAP)
- American Society of Colon & Rectal Surgeons (ASCRS)
- American Society of Plastic & Reconstructive Surgeons (ASPRS)
- American Urological Association, Inc. (AUA)

If you satisfy the requirements of any of the above organizations, you need *not* apply for the "Physician's Recognition Award."

If you do not qualify for the specialty organization programs listed above, you must apply directly to the AMA for the "Physician's Recognition Award." Upon receipt of the award, the AMA will notify the Kansas Medical Society that you have completed the requirement.

Questions concerning CME requirement can be directed to the Board or the Kansas Medical Society. The addresses of each are as follows:

The Kansas State Board of Healing Arts
503 Kansas Avenue
Topeka, KS 66603
Telephone: (913) 296-7413

The Kansas Medical Society
1300 Topeka Boulevard
Topeka, KS 66612
Telephone: (913) 235-2383

Each individual physician is responsible for recording his own hours of attendance at postgraduate courses. The credit hours should be recorded on the AMA Physician's Recognition Award application form when 150 hours are accumulated. The application form should then be mailed directly to the AMA, 535 North Dearborn, Chicago, IL 60610.



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140

130

120

110

100

90

80

70

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50

40

30

20

10

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In mild to moderate hypertension

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ONCE DAILY**

**CALCIUM
CHANNEL
BLOCKER...**

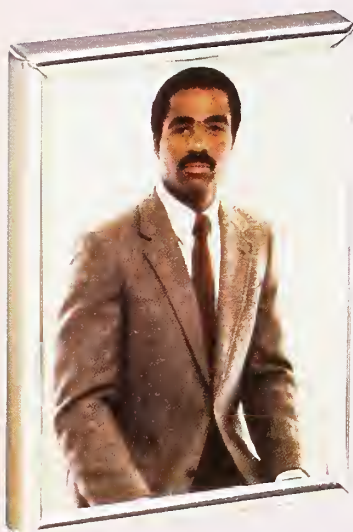
NEW
ONCE DAILY



ISOPTIN[®] SR^{*}

(verapamil HCl/Knoll)

240 mg scored, sustained-release tablets



JAMES B.
38, black male, heavy smoker. Prescribed a diuretic by another physician last year for hypertension.

YOUR CONCERNS
Presents with "smoker's cough." Workup reveals a BP of 150/107.

A LOGICAL CHOICE FOR CONTROL OF HIS BP
ISOPTIN[®] (verapamil HCl/Knoll) because...

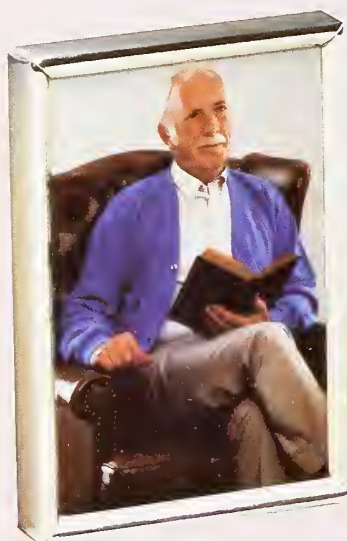
- Black hypertensives often have low plasma renin activity and generally do not respond favorably to beta blockers.
- Beta blockers may increase the likelihood of bronchospasm.

ALICE W.
65, diabetic, overweight. Her BP has elevated to 190/98.

YOUR CONCERNS
She's on daily insulin.

A LOGICAL CHOICE FOR CONTROL OF HER BP
ISOPTIN[®] (verapamil HCl/Knoll) because...

- Unlike most beta blockers and diuretics, ISOPTIN has no adverse effects on serum glucose levels.
- Unlike most beta blockers, ISOPTIN does not mask the symptoms of hypoglycemia.



THOMAS G.
70, asthmatic. In the past, BP adequately controlled with 25 mg hydrochlorothiazide daily.

YOUR CONCERNS
Today patient presents with symptoms of gout. Workup reveals high uric acid level, low serum potassium, and BP elevated to 180/98.

A LOGICAL CHOICE FOR CONTROL OF HIS BP
ISOPTIN[®] (verapamil HCl/Knoll) because...

- Unlike diuretics, ISOPTIN will not decrease serum potassium levels or elevate uric acid levels.
- Unlike beta blockers, ISOPTIN can be used safely in asthma and COPD patients.

JOHN K.
42, Annual physical uncovered diastolic BP of 102... confirmed on three successive office visits. Unresponsive to nonpharmacologic intervention.

YOUR CONCERNS
Salesman, spends many hours of his working day in car... total cholesterol level 300, HDL 35.

A LOGICAL CHOICE FOR CONTROL OF HIS BP
ISOPTIN[®] (verapamil HCl/Knoll) because...

- Unlike diuretics, ISOPTIN does not cause urinary urgency.
- Unlike either beta blockers or diuretics, ISOPTIN will not adversely affect his already seriously compromised lipid profile.
- Unlike with propranolol, fatigue and impotence are rarely reported.



**Antihypertensive therapy you
and your patients can live with**

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Please see adjacent page for brief summary.

**In mild to moderate hypertension
THE FIRST ONCE DAILY
CALCIUM CHANNEL BLOCKER**

Brief Summary

**ISOPTIN® SR
(verapamil HCl/Knoll)
240 mg scored, sustained-release tablets**

CONTRAINDICATIONS: 1) Severe left ventricular dysfunction (see WARNINGS), 2) Hypotension (less than 90 mmHg systolic pressure) or cardiogenic shock, 3) Sick sinus syndrome or 2nd or 3rd degree AV block (except in patients with a functioning artificial ventricular pacemaker).

WARNINGS: **Heart Failure:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (see DRUG INTERACTIONS). Patients with milder ventricular dysfunction should, if possible, be controlled before verapamil treatment. Hypotension: ISOPTIN (verapamil HCl) may produce occasional symptomatic hypotension. Elevated Liver Enzymes: Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Periodic monitoring of liver function in patients receiving verapamil is therefore prudent. Accessory Bypass Tract (Wolff-Parkinson-White): Patients with paroxysmal and/or chronic atrial flutter or atrial fibrillation and a coexisting accessory AV pathway have developed increased antegrade conduction across the accessory pathway producing a very rapid ventricular response or ventricular fibrillation after receiving intravenous verapamil. While this has not been reported with oral verapamil, it should be considered a potential risk. Treatment is usually D.C.-cardioversion. Atrioventricular Block: The effect of verapamil on AV conduction and the SA node may cause asymptomatic 1st degree AV block and transient bradycardia. Higher degrees of AV block, while infrequent (0.8%), may require a reduction in dosage or, in rare instances, discontinuation of verapamil HCl. Patients with Hypertrophic Cardiomyopathy (IHSS): Although verapamil has been used in the therapy of patients with IHSS, severe cardiovascular decompensation and death have been noted in this patient population.

PRECAUTIONS: Impaired Hepatic or Renal Function: Verapamil is highly metabolized by the liver with about 70% of an administered dose excreted in the urine. In patients with impaired hepatic or renal function verapamil should be administered cautiously and the patients monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacological effects (see OVERDOSAGE).

Drug Interactions: Beta Blockers: Concomitant use of ISOPTIN and oral beta-adrenergic blocking agents may be beneficial in certain patients with chronic stable angina or hypertension, but available information is not sufficient to predict with confidence the effects of concurrent treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities. Digitalis: Clinical use of verapamil in digitalized patients has shown the combination to be well tolerated if digoxin doses are properly adjusted. However, chronic verapamil treatment increases serum digoxin levels by 50 to 75% during the first week of therapy and this can result in digitalis toxicity. Upon discontinuation of ISOPTIN (verapamil HCl), the patient should be reassessed to avoid underdigitalization. Antihypertensive Agents: Verapamil administered concomitantly with oral antihypertensive agents (e.g., vasodilators, angiotensin-converting enzyme inhibitors, diuretics, beta blockers, prazosin) will usually have an additive effect on lowering blood pressure. Patients receiving these combinations should be appropriately monitored. Disopyramide: Disopyramide should not be administered within 48 hours before or 24 hours after verapamil administration. Quinidine: In patients with hypertrophic cardiomyopathy (IHSS), concomitant use of verapamil and quinidine resulted in significant hypotension. There has been a report of increased quinidine levels during verapamil therapy. Nitrates: The pharmacologic profile of verapamil and nitrates as well as clinical experience suggest beneficial interactions. Cimetidine: Two clinical trials have shown a lack of significant verapamil interaction with cimetidine. A third study showed cimetidine reduced verapamil clearance and increased elimination to 1/2. Anesthetic Agents: Verapamil may potentiate the activity of neuromuscular blocking agents and inhalation anesthetics. Carbamazepine: Verapamil may increase carbamazepine concentrations during combined therapy. Rifampin: Therapy with rifampin may markedly reduce oral verapamil bioavailability. Lithium: Verapamil may lower lithium levels in patient on chronic oral lithium therapy. Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no evidence of a carcinogenic potential of verapamil administered to rats for two years. Verapamil was not mutagenic in the Ames test. Studies in female rats did not show impaired fertility. Effects on male fertility have not been determined. Pregnancy (Category C): There are no adequate and well-controlled studies in pregnant women. ISOPTIN crosses the placental barrier and can be detected in umbilical vein blood at delivery. This drug should be used during pregnancy, labor, and delivery, only if clearly needed. Nursing Mothers: ISOPTIN is excreted in human milk, therefore, nursing should be discontinued while verapamil is administered. Pediatric Use: Safety and efficacy of ISOPTIN in children below the age of 18 years have not been established.

ADVERSE REACTIONS: Constipation 8.4%, dizziness 3.5%, nausea 2.7%, hypotension 2.5%, edema 2.1%, headache 1.9%, CHF/pulmonary edema 1.8%, fatigue 1.7%, bradycardia 1.4%, 3° AV block 0.8%, flushing 0.1%, elevated liver enzymes (see WARNINGS). The following reactions, reported in less than 1.0% of patients, occurred under conditions (open trials, marketing experience) where a causal relationship is uncertain; they are mentioned to alert the physician to a possible relationship: angina pectoris, arthralgia and rash, AV block blurred vision, cerebrovascular accident, chest pain, claudication, confusion, diarrhea, dry mouth, dyspnea, ecchymosis or bruising, equilibrium disorders, exanthema, gastrointestinal distress, gingival hyperplasia, gynecomastia, hair loss, hyperkeratosis, impotence, increased urination, insomnia, macules, muscle cramps, myocardial infarction, palpitations, paresthesia, psychotic symptoms, purpura (vasculitis), shakiness, somnolence, spotty menstruation, sweating, syncope, urticaria. Treatment of Acute Cardiovascular Adverse Reactions: Whenever severe hypotension or complete AV block occur following oral administration of verapamil, the appropriate emergency measures should be applied immediately, e.g., intravenously administered isoproterenol HCl, levarterenol bitartrate, atropine (all in the usual doses), or calcium gluconate (10% solution). If further support is necessary, inotropic agents (dopamine or dobutamine) may be administered. Actual treatment and dosage should depend on the severity and the clinical situation and the judgment and experience of the treating physician.

OVERDOSAGE: Treatment of overdosage should be supportive. Beta-adrenergic stimulation or parenteral administration of calcium solutions may increase calcium ion flux across the slow channel, and have been used effectively in treatment of deliberate overdosage with verapamil. Clinically significant hypotensive reactions or fixed high degree AV block should be treated with vasopressor agents or cardiac pacing, respectively. Asystole should be handled by the usual measures including cardiopulmonary resuscitation.

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2474/11/86

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Facing Cancer Together

(Continued from page 161)

another. The recognition they must experience has been well described by Naylor⁵: To be entrusted with this kind of responsibility is recognition in itself, but we must be ever watchful for the opportunity to express appreciation on behalf of those who may not be able to express it — not just with pins or certificates at the end of the year, but with a special word from other staff people who observe the contribution made by the volunteer and communicate respect for the caliber of person who assumes this kind of service.

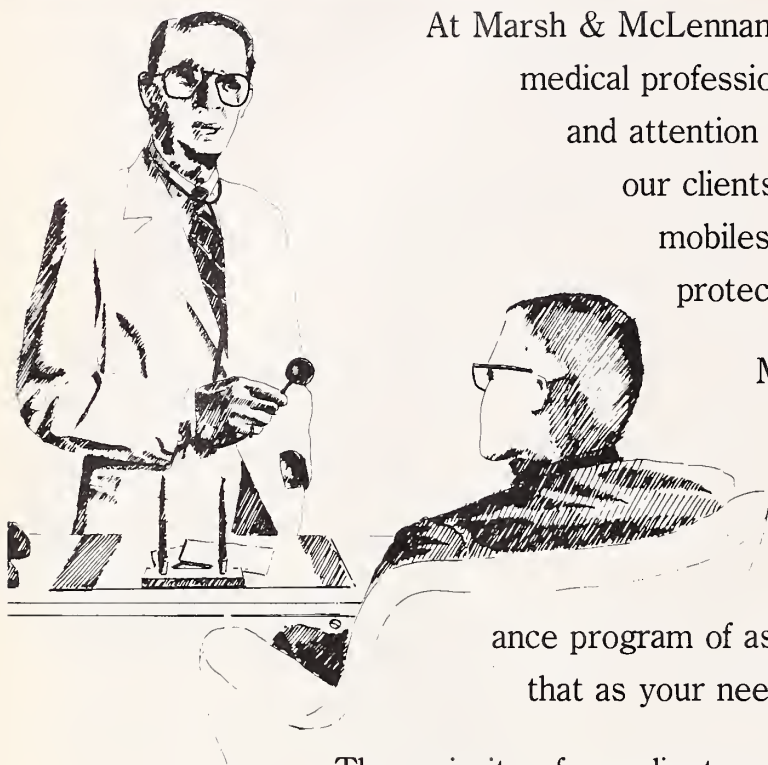
The special skills, time, and empathy that patients can have for one another are resources too valuable to be ignored or wasted. The process of assisting those to leave life in the most dignified way possible is too important a job to leave only to the professionals.

References

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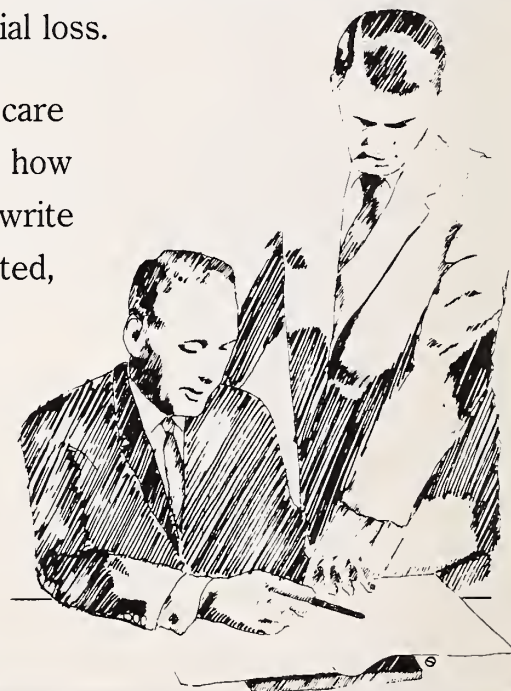
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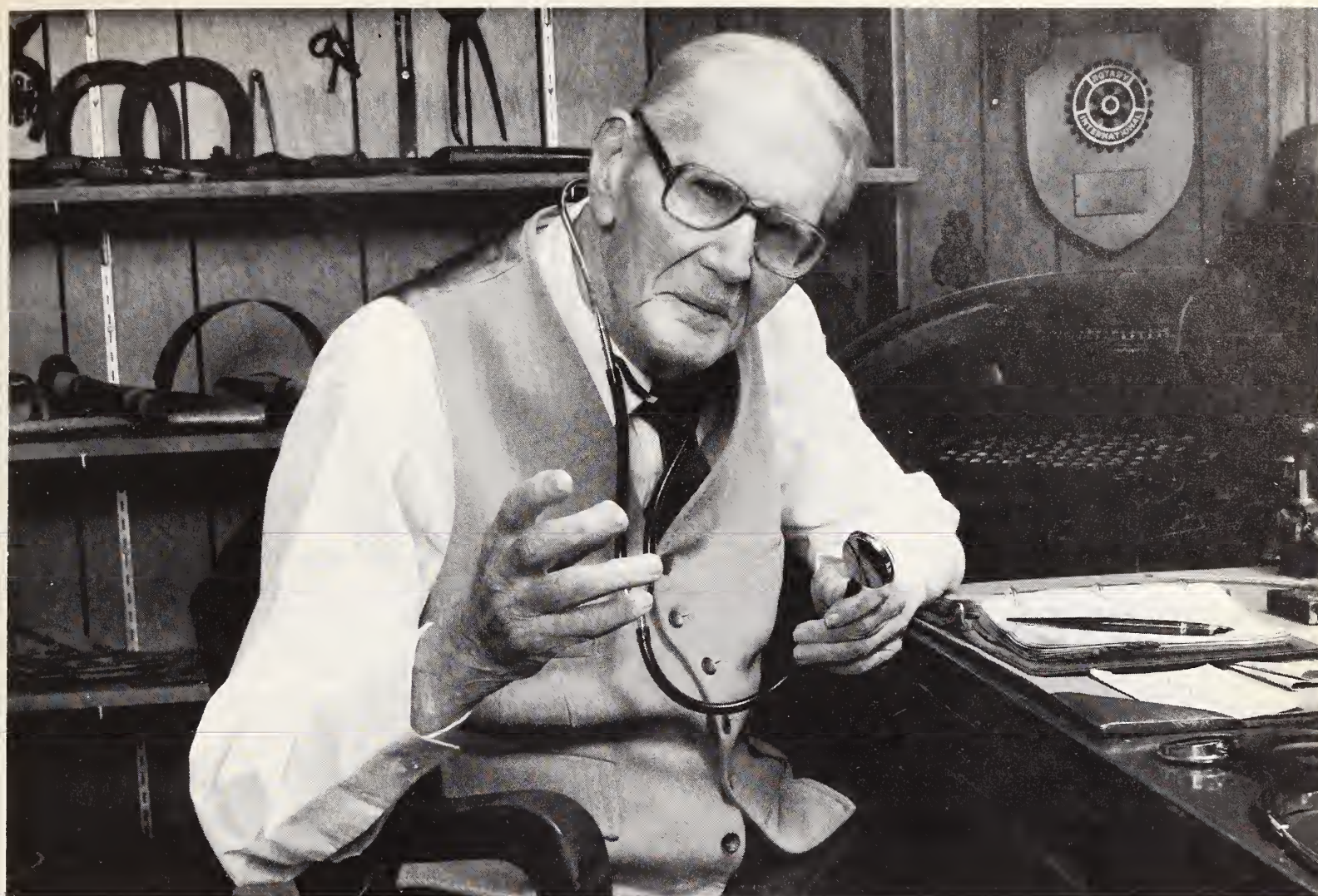
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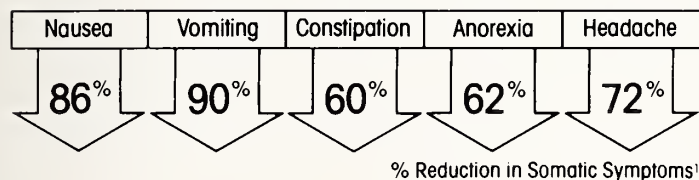
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References: 1. Feighner JP, et al: *Psychopharmacology* 61: 217-225, Mar 22, 1979. 2. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation at either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring



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reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects at both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

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Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

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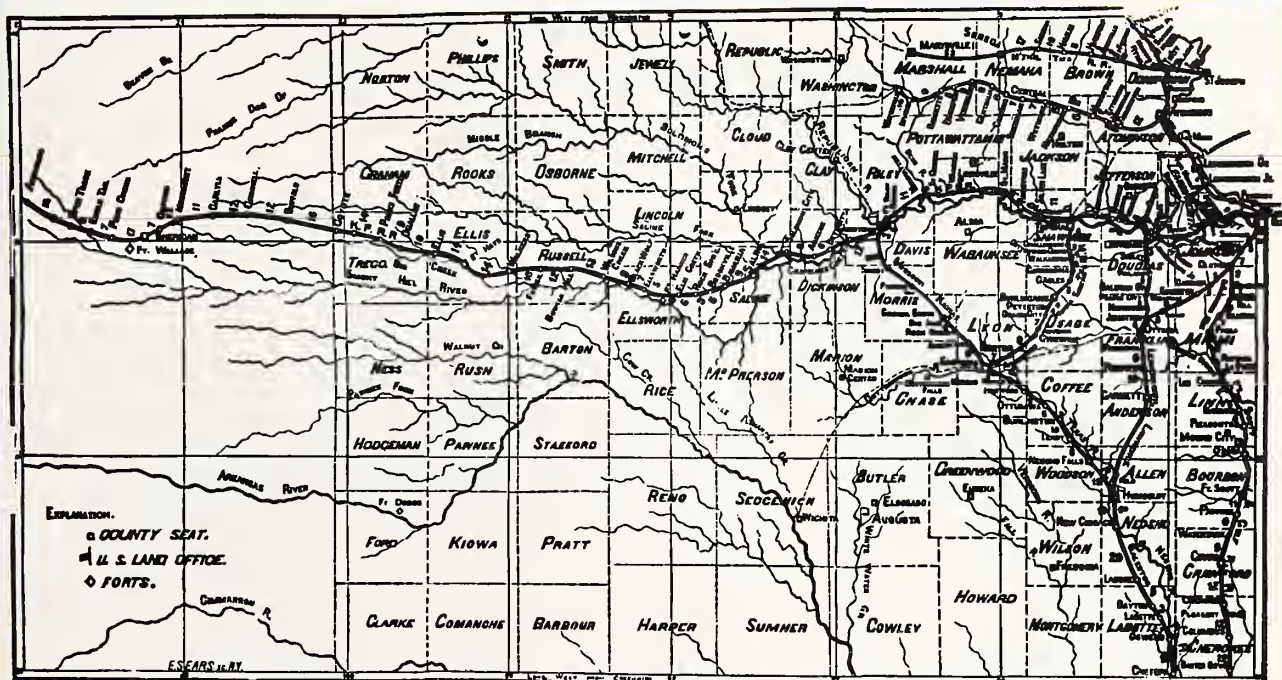
SEE THE DIFFERENCE IN THE FIRST WEEK¹



Please see references and summary of product information on adjacent page.

KANSAS MEDICINE

Volume 88, Number 6, June 1987 ISSN 8755-0059



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This map of Kansas illustrates a leaflet of the Kansas Immigration Society, printed at Leavenworth in 1871. An accompanying certificate signed by Gov. James M. Harvey and other prominent state officials, and by representatives of three major railroads, endorses the aims and methods of the society in proposing to induce immigration by homeseekers.

Cardiac Resuscitation in Rural Kansas	187
Hypnotherapy for Chronic Pain	190
Male Contraception and AIDS Prevention	193
Postinfarction Myocardial Rupture	195
Health Care Stewardship	196
KMS Newsletter	192a

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Volume 88, Number 6, June 1987

Contents

Scientific Articles

- Cardiac Resuscitation in Rural Kansas — Randy F. Jones, M.I.C.T. and Jack A. Wortman, M.D., Hutchison
Improved training, new techniques, and added equipment and personnel have increased the percentage of successful out-of-hospital resuscitations in Hutchinson/Reno County 187
- Hypnotherapy for Chronic Pain — Maurice M. Tinterow, M.D., Ph.D., Wichita
Chronic pain is difficult to treat, and hypnotherapy may be of benefit to some patients for long-term control of pain 190
- Male Contraception and AIDS Prevention: The Need for Involvement by Kansas Physicians — M. Brown, R.N., B.S.N., Topeka
Physicians can help to educate males to reduce the number of unintended pregnancies and to inhibit the spread of AIDS and other STDs 193
- Aggressive Early Management of Postinfarction Myocardial Rupture — Zack A. Razek, M.D. and William Hayes, M.D., Wichita
There is evidence that aggressive early management of this complication can improve the chances of survival for patients with myocardial infarction 195
- Health Care Stewardship — Francis E. Cuppage, M.D.; Marcia Wrona, B.S.W. and Ruth Hassanein, Ph.D., Kansas City, Kansas
It has been found that health care professionals tend to give generously of their time and money for various stewardship activities 196

Miscellaneous

- Classified Advertisements 185
- Cover Story 179
- Editorial Comment: Uncertain Certainties 200
- Information for Authors 207
- KMS Newsletter 192a
- Medicina et Lex 201
- Physician Directory 186
- President's Message 199

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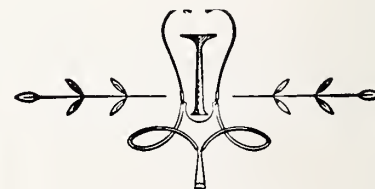
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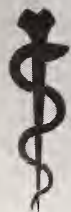
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Cover Story

IF THE 19TH CENTURY brought to the United States the title "The Melting Pot," its 34th state was no less deserving of it. As the territory, then the state, of Kansas opened up, it brought to the area representatives of numerous national and ethnic origins not all of whom were "huddled masses" but certainly "yearning to breathe free" which the expanse of land, despite early problems, permitted in large measure.

The variety of origins was extensive. It would be an oversight to forget that the "original" inhabitants, now designated "Native Americans," were first of all immigrants whether they came across the Bering Strait, down from the northeast, or whatever direction those many centuries ago. Still, they are entitled to be called "native" by those who came during the years we inaccurately label "the early days." The trappers, explorers, trailblazers, and others who came with whatever intent left historical remnants but only indirectly affected the population mix in the sense that later immigrants would.

If the Eastern Seaboard (New York in particular) filtered out many of the immigrants from across the Atlantic, Kansas had a strong appeal for some (although they would scarcely know why — except from the stories they heard from others). The stories behind their coming are, in fact, the basic history of the state. There were Germans, Russians and German-Russians, Scandinavians (mostly Swedes), English, Scots and Irish, and Czechs (then known as Bohemians). Mexican-Americans moved up from the south to work on the expanding railroads, first as laborers, then — as they brought their families and settled in — becoming business and professional people as well as civic leaders. Blacks, coming individually as escaped slaves or freedmen at first, became the Exodusters after the Civil War.

Diverse factors played roles in the movement. The story of the German groups moving to Russia at the invitation of Catherine the Great (and to avoid military conscription) and the later change of political and military controls brought by Nicholas II (as universal military conscription was again established in Russia) are well known to Kansans (not only their descendants). Their contributions of "Turkey Red" hard winter wheat, their examples of industry brought incalculable benefits to the state. It was a famine in Sweden that started a marked influx of Swedes into the area. Religions contributed to the attraction of the area and virtually every form was represented to some degree: Catholics, Lutherans, Anglicans and their offspring Episcopalians, Mennonites, Congregationalists, Baptists, Methodists, and more gradually the Jewish and other denominations of lesser number, but all left marks of their presence. In some cases, the religious convictions accounted for an insularity aimed

at retaining those convictions when confronted with the worldly realities of frontier survival. (The Mennonites, with their dedication to the "plain" and industrious life, are well-known examples.) But gradually there has been a coalescence of effect, transcending while supporting these convictions, into the fabric of the state.

Idealistically as the picture may be portrayed, however, there were, in practice, the inevitable political and commercial influences making it reality. The federal government's Homestead Act of 1862 provided a strong invitation to settlers to take advantage of the availability of the expanse of land. Added encouragement was given to the now expanding railroads in the form of land grants. Besides the straight grants of money and bond sales by local governments, the federal government gave the roads millions of acres along their right-of-ways to put at the disposal of settlers, basing the amount of land on the number of miles of track completed. (See the cover for May for the Santa Fe's allowance.) Settlers could, of course, take the land in checkerboard fashion — title going to different family members but taken in checkerboard sections so that others were effectively prevented from getting to the enclosed sections.

These factors, then, combined to produce a selling campaign by the railroads to the Europeans worthy of 20th Century methods. Their agents spread over the continent with word of the literally promised land. Lurid handbills and pamphlets initiated or bolstered dreams of independence, freedom, even wealth — although perhaps not the "Streets of Gold" concept that would invite others. One agency that fostered the effort was the Kansas Immigration Society which provided for prospects and new arrivals a map produced by the Kansas Pacific (cover, courtesy of the Kansas State Historical Society, from Baughman's *Kansas in Maps*) showing stations along its route. This would give prospective customers a sense of location even though the reality would remain uncertain until arrival. Although perhaps unknown to them at the time, it was the Constitution that supported this promise of the "pursuit of happiness."

As the next century brought changes in communication and transportation as well as continuing political and military upheavals in their home countries, representatives of other nations, notably in more recent times those from the other side of the Pacific, added their effects. It has been characteristic that family and ethnic groups retained their specific individuality, attracting others of the same origin and bringing their versions of ethics and industry. But the histories of state and nation reveal a unique assimilation of people and principles that has been the strength of both. — D.E.G.





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month after month with
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*Please see brief summary of
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The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psychosocial difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

First Episodes (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

Recurrent Episodes:

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This

approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

CONTRAINDICATIONS: Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

WARNINGS: Zovirax Capsules are intended for oral ingestion only.

PRECAUTIONS: General: Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

Drug Interactions: Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F₁ generation. Although not statistically significant,

there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week post-dose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS — Short-Term Administration: The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

Long-Term Administration: The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

Chronic suppressive therapy for recurrent disease: One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

Intermittent Therapy: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

Patients With Acute or Chronic Renal Impairment: One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance ≤ 10 ml/min/1.73/m².

HOW SUPPLIED: Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200". Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

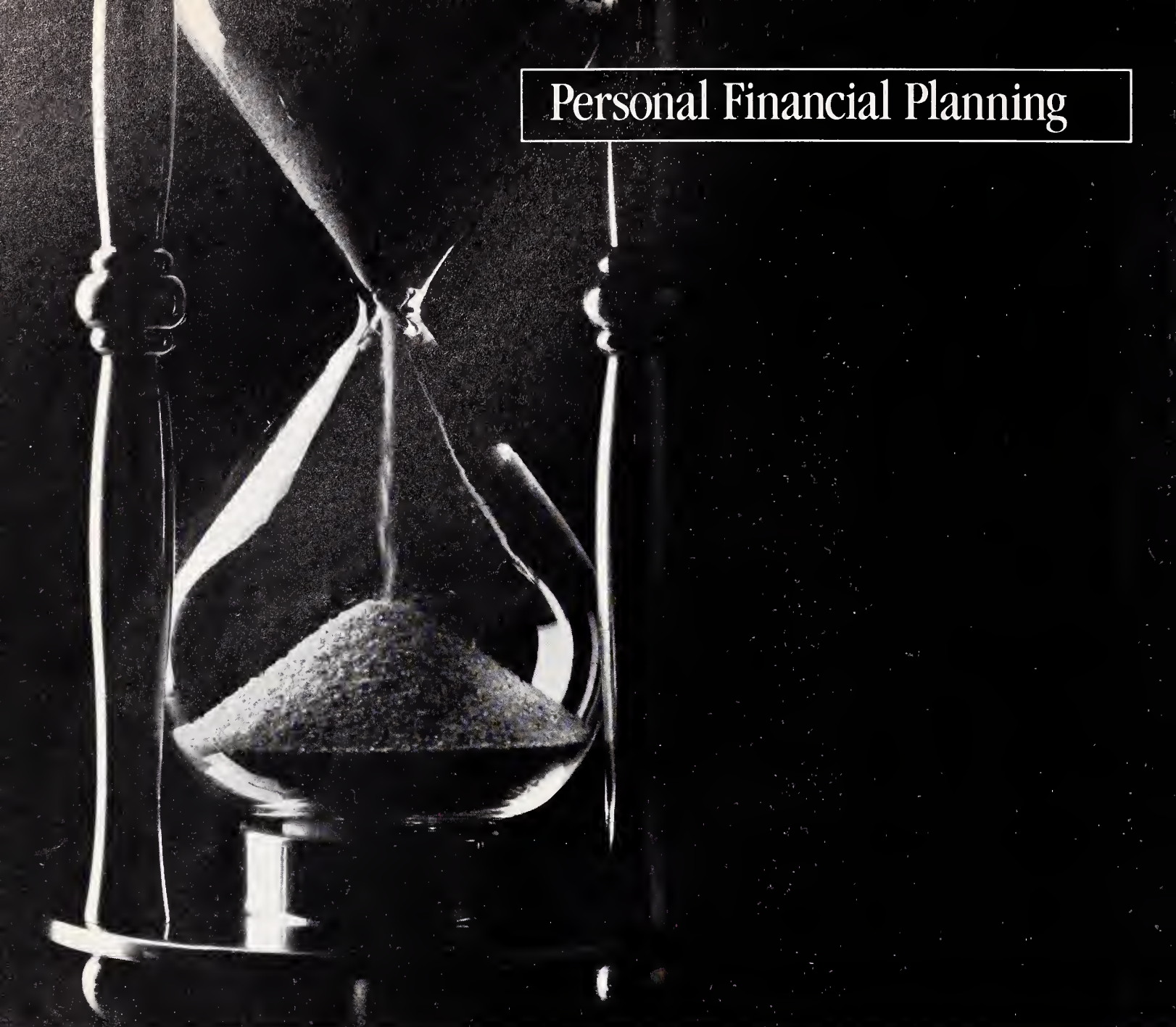
Store at 15°-30°C (59°-86°F) and protect from light.

*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.



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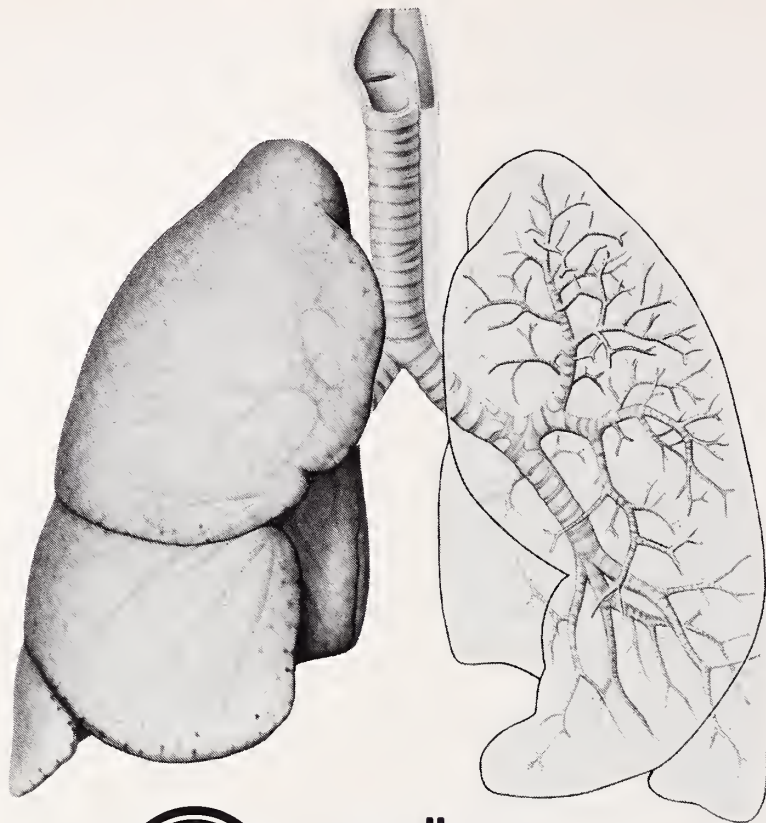


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Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication:
Known allergy to cephalosporins.

Warnings:

CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients. Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness,

insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.

• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

[072866R]

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Before prescribing, see complete prescribing information in SK&F CO literature or PDR. The following is a brief summary.

*** WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide, dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules, Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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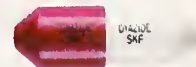
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SCIENTIFIC ARTICLES

Cardiac Resuscitation in Rural Kansas

RANDY F. JONES, M.I.C.T. and JACK A. WORTMAN, M.D., *Hutchinson*

SINCE THE PIONEERING efforts of Kouwenhoven¹ in external cardiac compression in 1960 and the subsequent development of the mobile coronary concept by Pantridge,² Grace,³ and others in the late 1960s, treatment of out-of-hospital cardiac arrest has become practical, effective, and widely available.

In Hutchinson and Reno County an emergency service of the emergency medical technician (EMT) type was organized in 1971 as a cooperative venture between Reno County, the City of Hutchinson, and Hutchinson Hospital Corporation. In 1976 this system advanced to paramedic status with the employment of cardioactive drugs, as well as monitoring and defibrillation capability according to American Heart Association advanced life support algorithms. In 1981, in cooperation with the Department of Anesthesiology of Hutchinson Hospital, all paramedics were trained in endotracheal intubation and began field utilization of this technique.

Initially all ambulances were dispatched from Hutchinson Hospital; however, due to the sizeable geographic area served by the system, a second dispatch station was opened in 1983, which resulted in improved response times to all parts of the city and county. Additionally, four EMT volunteer ambulance corps supplement the coverage of rural areas of the county.

This study was undertaken to evaluate the impact of various logistic and therapeutic interventions upon survival in out-of-hospital cardiac arrest.

Methods

Data were gathered retrospectively by careful review of standardized reports of a series of resuscitations. Special attention was given to response time, bystander cardio-pulmonary resuscitation (CPR), initial documented cardiac rhythm, number

of defibrillatory shocks given, endotracheal intubation, medications employed, medication dosage, and number of emergency medical services (EMS) personnel involved in the resuscitation.

Data collected from the years 1980-1981 reflect paramedic care without full Advanced Cardiac Life Support (ACLS) capabilities. The period of 1984 through the first half of 1986 represents paramedic care with full ACLS capabilities. Only non-trauma related cardiac arrests were included with a total of 216 patients studied (*Table I*).

Statistical analysis was limited to calculation of mean values and standard deviation of numerical data. Percentages and graphic representation of data were reviewed to seek trends in the delivery of care that seemed to correlate with improved likelihood of survival.

Discussion

Studies from Seattle,⁴ Belfast,² and other areas have clearly defined the time window for success in resuscitation. Our data indicate a response time of 9.2 ± 5.9 minutes for calls from a single station in 1980. With increasing personnel experience plus a second dispatch site, this time has been reduced to 6.6 ± 5.8 minutes in 1986 with the high standard of deviation interpreted as a reflection of the increasingly frequent joint responses with the volunteer EMT units in rural areas of the county. Response time within the City of Hutchinson is documented at 4.58 ± 1.73 minutes in 1986.

The percentage of patients who received CPR at the time of arrival of EMS was in the 60-70% range in the 1980-81 data and has gradually fallen to 50% and below in 1986. This change reflects, we believe, the effect of slower response time in 1980 that permitted arrival of other public service personnel — such as police or fire rescue — who commenced CPR prior to the arrival of the ambulance unit. This does not seem to reflect a change in the frequency of citizen or bystander CPR. The 50%

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TABLE I
EMERGENCY SERVICES DATA 1980-1981

	1980			1981			1984			1985			1986 est. (7-1-1986)		
Time to arrive at scene from dispatch	$\bar{X}$ 9.21min	σ 5.9min		$\bar{X}$ 6.33min	σ 3.06min		$\bar{X}$ 5.9min	σ 3.4min		$\bar{X}$ 6.97min	σ 5.59min		$\bar{X}$ 6.60min	σ 5.8min	
Time spent at scene	23.87min	8.84min		23.1min	7.47min		24.8min	6.7min		24.42min	5.44min		29.55min	8.78min	
% CPR Progress	58%			71.1%			42%			61.0%			50%		
Initial Lethal Rhythm	A=58% VF=31.5% E=9%			A=42% VF=46.6% E=8.9%			A=42% VF=30% E=23% I=6%			A=43.9% VF=29.3% E=24.9%			A=50% VF=23.7% E=26.3%		
Ave Number of Defib.	0.9 times			1.04 times			0.85 Times			1.59 Times			1.16 Times		
% of successful Intubation	EOA 76.3%			EOA 71.1%			ET 91.0%			ET 91%			ET 78.9%		
Medications	Ave used	$\bar{X}$	σ	Ave used	$\bar{X}$	σ	Ave used	$\bar{X}$	σ	Ave used	$\bar{X}$	σ	Ave used	$\bar{X}$	σ
Epinephrine	73.7%	.67mg	.43mg	68.9%	.69mg	0.3mg	96.2%	1.1mg	0.54mg	97.6%	1.48mg	.63mg	86.8%	1.89mg	0.92mg
NaHCO ₃	71.1%	150mEq	33mEq	73.3%	126mEq	33mEq	90.6%	14.1mEq	30mEq	97.6%	142mEq	42mEq	68.4%	120mEq	41mEq
Atropine	10.5%	.64mg	.46mg	8.9%	1mg	0mg	35.8%	0.82mg	0.3mg	63.4%	0.98mg	0.1mg	60.5%	.97mg	.42mg
CaCl ₂	31.6%	679mg	421mg	35.6%	500mg	0mg	73.6%	799mg	369mg	75.6%	903mg	300mg	47.4%	875mg	422mg
Lidocaine	10.5%	106mg	67mg	13.3%	87.5mg + 1mg/min		17.0%	108 + 3mg/min		31.7%	96.7mg + 3.5mg/min		23.7%	123mg + 2mg/min	
Isuprel	3%	2mg	0mg	0%			5.7% titrated			14.6% titrated			18.4% titrated		
Bretylium	0%			0%			1.9%	500mg	0mg	14.6%	525mg	248mg	2.6%	1000mg	0mg
Oopamine	0%			0%			1.9%	60gtt/min	0gtt	7.3%	titrated		2.6%	6mcg/min + 2mcg/min	
Ave. No. Tech.	2.29 Tech.			2.08 Tech.			2.83 Tech.			2.9 Tech.			3.13 Tech.		
Field Saves	$\bar{X}$	σ		$\bar{X}$	σ		$\bar{X}$	σ		$\bar{X}$	σ		$\bar{X}$	σ	
% of Field Saves	7%			10.5%			15.1%			19.5%			28.9%		
% Long Term Saves	5%			4.0%			3.7%			9.8			15.8%		
% Long Term to Short Term	75%			40%			25%			50%			54.5%		
Time to arrive at scene from dispatch	9.25min	2.5min		4.8min	3.3min		4.63min	.74min		6.25%	6.32min		6.64min	4.08min	
Time spent at scene	17.0min	7.9min		26min	5.7min		27.5min	4.7min		25.4min	4.07min		24.63min	7.55min	
% CPR in Progress	100%			40%			25%			50%			36.4%		
Initial Lethal Rhythm	A=25% VF=75%			VF=80% E=20%			A=12.5% VF=75% E=12.5%			A=12.5% VF=87.5%			A=27.3% VF=45.5% E=27.3%		
Ave. No. of Defib.	2.25 times			2.2 times			1.86 times			1.875 times			1.73 times		
% of successful Intubation	EOA 75%			EOA 40%			ET 75%			ET 87.5%			ET 63.6%		
Medications	Ave used	$\bar{X}$	σ	Ave used	$\bar{X}$	σ	Ave used	$\bar{X}$	σ	Ave used	$\bar{X}$	σ	Ave used	$\bar{X}$	σ
Epinephrine	25%	0.5mg	0mg	40%	0.5mg	0mg	75%	0.75mg	.27mg	100%	1mg	.53mg	54.5%	1.58mg	0.8mg
NaHCO ₃	100%	162.5mEq	25mEq	60%	116.7mEq	29mEq	62.5%	145mEq	6.7mEq	100%	127mEq	34mEq	63.6%	109mEq	44mg
Atropine	0%			0%			0%			50%	1mg	0mg	27.3%	0.67mg	0.29mg
CaCl ₂	0%			0%			25%	500mg	0mg	37.5%	500mg	0mg	18.2%	625mg	530mg
Lidocaine	50%	150mg	70.7mEq	60%	100mg + 1mg/min		62.5%	120mg + 2.5mg/min		75%	100mg + 2.5mg/min		63.6%	142mg + 3.5mg/min	
Isuprel	0%			0%			0%			25% titrated			0%		
Bretylium	0%			0%			12.5%	500mg	0mg	12.5%	350mg	0mg	0%		
Oopamine	0%			0%			12.5%	60gtt/min	0gtt	12.5%	900mcg	0mcg	9.1%	3mg/min	0mg
Ave. No. Tech.	2.5 Tech.			2.0 Tech.			2.875 Tech.			3.25 Tech.			3.09 Tech.		

Asystole = A
V-Fib = VF
EMD = E
Idioventricula = I

figure is disappointingly low considering the ready access to CPR training in the community, and emphasizes the continuing need for efforts toward increasing awareness of the need for CPR training among the lay public. It is a subjective, although we believe valid, observation that bystander CPR among the geriatric population is uncommon.

The incorporation of CPR training into the physical education curriculum of the local middle school and high school has been a constructive step, and would be a desirable model for all secondary schools in Kansas. Ready availability of training to church, social, and civic groups including the elderly, to the highest degree possible, remains an important goal.

The field use of endotracheal intubation has been a major advance in emergency cardiac care, not only for the provision of adequate ventilation and oxygenation, but as protection against aspiration and as an alternative route for the delivery of cardioactive medications.

It is noteworthy that the number of out-of-hospital successful resuscitations during the first three months

of field intubation exceeded the number for the preceding year. Field intubation was successful in 80-90% of attempts overall.

The percentage of initial dysrhythmias identified and documented has been fairly consistent throughout the study period with about 50% of victims in asystole, 30-40% in ventricular fibrillation, and some 10% in electromechanical dissociation. Overall, the best salvage rate occurred in patients who presented with ventricular fibrillation. Successful defibrillation on the first or second attempt was the common pattern.

Evaluation of medication given indicates a trend toward increasing dosage of adrenalin given early in the resuscitation process. The initial dose is given through the endotracheal tube with increasing frequency allowing pharmacologic therapy to commence even before the intravenous lifeline is established. Dosage totals of adrenalin in 1980 were 0.67 ± 0.43 milligrams and have risen in 1986 to 1.89 ± 0.92 milligrams. A positive correlation with patient survival is consistent with the recommendations of Ewy⁵ and others who note that alpha ad-

renergic drugs increase aortic diastolic pressure improving coronary perfusion during CPR thereby enhancing myocardial viability.

The utility of other medications including sodium bicarbonate, atropine, calcium chloride, Isuprel, lidocaine, bretylium and dopamine was difficult to assess. There was no clear-cut indication that these medications enhanced survival.

During the study period the experience of individual EMS personnel has increased and total numbers of personnel have increased as well. Currently 17 full-time paramedics, several part-time EMT's, and a ten-member reserve squad constitute the EMS staff. Average experience is six years with a staff turnover of about 10% annually. The addition of a third member to the response team has improved the ease and efficiency of the resuscitation allowing one rescuer to manage airway, one to provide external cardiac compression, and the third to manage the intravenous lifeline, monitoring, and defibrillation equipment. Frequently public service personnel do basic life support care so all three paramedics can devote their full attentions to ACLS care.

Conclusions

During the study period, the percentage of successful out-of-hospital resuscitations in Hutchinson and Reno County has increased significantly from 7% field saves with 5% long-term survival in 1980 to 29% field saves with 16% long-term survival in the first half of 1986 (*Figure 1*). Review of the data we have accumulated suggests several variables which taken collectively correlate with improved likelihood of survival from out-of-hospital cardiac arrest. These include prompt response time, adequate numbers of rescuing personnel, ability to perform endotracheal intubation, early defibrillation, early and adequate dosage of adrenalin, and application of full ACLS measures according to standing orders.

The American Heart Association Textbook of Advance Cardiac Life Support provides a systematic approach to the delivery of emergency cardiac care. The recently revised Standards and Guidelines for Cardiopulmonary Resuscitation and Emergency

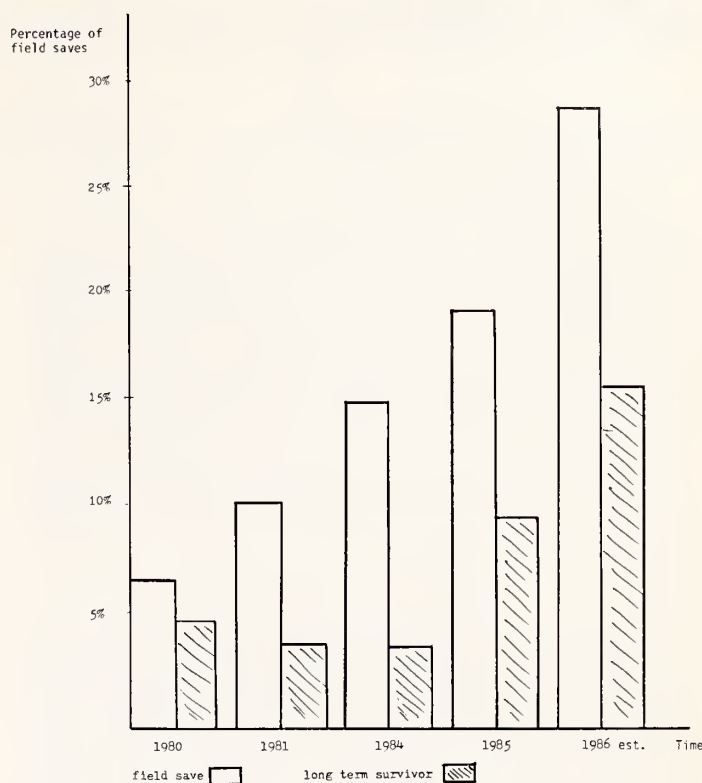


Figure 1. Short-term and long-term survivors.

Cardiac Care⁶ provides an updated outline of the techniques of resuscitation, as well as current algorithms for cardiovascular drugs used in cardiac arrest. Application of these measures has resulted in a significant increase in survivors of out-of-hospital cardiac arrest treated in this area.

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***Be an effective advocate for the medical profession.
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Hypnotherapy for Chronic Pain

MAURICE M. TINTEROW, M.D., Ph.D.,* *Wichita*

CHRONIC PAIN is the most difficult symptom to treat, and all types of therapy should be used to help those who suffer continuous chronic pain. The dilemma of therapy for relief of chronic pain continues, and researchers continue to postulate theories for its mechanism of action. The study reported here involved 178 patients who were treated with hypnosis for chronic pain that had failed to respond to other methods of treatment.

History

Mesmerism, introduced by Franz Anton Mesmer in the 1780s, was the first technique used for removing the sensation of pain. His "animal magnetism" became popular in the late 18th century, but his claim of a magnetic force (which he perceived to be in his body) to remove ailments was not verified by his fellow physicians. Mesmerism did not achieve the popularity Mesmer had hoped for, and he was banned from France after a committee, consisting of Benjamin Franklin, M. de Guillotin, and others were unable to verify the results of his treatments. Mesmer left France and went to Switzerland, where he lived for a while and died a disgruntled old man.

However, there were some physicians who were impressed by results they had achieved using Mesmer's techniques, and the practice continued in France, England, and other European countries. James Esdaile (1808-1859), an English surgeon who was stationed in India, performed a variety of surgical operations on Hindus and appeared to have successfully induced hypnotism (mesmerism) and hypnotic anesthesia (mesmeric anesthesia) as the sole agent for surgery. Esdaile states, "My experience has demonstrated the singular and beneficial influence exerted by Mesmerism over the natives of Bengal, and that painless surgical operations, with other advantages, are their natural birthright, of which they will no longer be deprived." Esdaile lists 73 surgical procedures which he performed in 1846. These included amputation of the arm, breast,

and penis. Scrotal tumors were removed, as well as a large tumor of the leg. However, he also reported a number of medical cases which he said were cured by mesmerism during eight months of practice in India (*Table I*).¹

It was not until the middle of the 20th century that the British and American Medical Societies recognized the use of hypnotism as an adjunct to treatment for pain relief. James Braid, who coined the word "hypnosis" in his writings, was the first to report that hypnosis was a utilization of suggestion, but did not realize that suggestion was the underlying process.² Even Freud rejected hypnosis in favor of his own theories, and relegated hypnosis back to the stage of amusement and mystery. During the last 30 years, research and clinical studies have stimulated interest, and today it is accepted as an adjunct to medical practice, particularly for the relief of painful conditions.

Today chronic pain is the symptom that brings patients to the physician. Back pain is the number one cause of lost work days. Analgetics are sold by the billions both over the counter and by prescription. How should the patient with chronic pain be treated? The cause has been removed, but the pain lingers. It is well known that distraction from attention may exclude many sensations — including pain — from consciousness. It will vary with the emotional and physical makeup of the patient. Pain is experiential in nature, and what one feels is not what another may feel; however, the physician can perceive the discomfort of the patient. Variations

TABLE I
MEDICAL CONDITIONS REPORTED CURED
BY ESDAILE¹

Nervous headache	3 cured by 1 trance
Tic douloureux	1 cured by 1 trance
Sciatica	1 cured by 1 trance
Acute inflammation of the testes	1 cured by multiple trances
Lameness from rheumatism	2 cured by local mesmerizing for a week
Pain in crural nerve	1 cured by 1 trance
Rheumatism	1 cured by mesmerizing daily

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in the perception of pain, its minimization, distortion or exaggeration, occur because of associated attitudes or emotions. The first priority to be established by the physician is that the pain is "real." If patients have pain for psychological reasons — and many do — this must occur because of the operation of mutual mechanisms that produce it independently of the patient's consciousness. Pain may also arise as a result of a conversion symptom or as a depressive reaction. In all of these cases, the patient's experience must be honored, and the experience must be investigated or discussed. This pain is always a psychological experience, and as such, is susceptible to modalities that challenge the human mind, and offer the sought-after relief as a basis for therapy.

The dramatic pain suppressant effect of hypnosis has long been a source of discussion and controversy. Surgical procedures ranging from appendectomies to thyroidectomies, from Cesarean sections to open heart surgery, have been performed without chemical anesthesia or as an adjunct to narcotic analgesia, providing impressive and tangible evidence of the role of psychological factors in suppressing pain.³ Although it cannot be doubted that these procedures have been carried out with the use of hypnosis, the interpretation of this fact remains a source of controversy. Many surgical procedures have been devised for the relief of chronic pain; however, these have not been accepted as desirable because of their destructive nature. Hypnosis has been suggested to be a "psychologic" lobotomy, but hypnosis was tried before and after prefrontal lobotomy, and it did not make the patient more easily hypnotizable as it should if it were a surgical and permanent form of the same state of mind.⁴ Neurectomy, rhizotomy, chordotomy, and ablation of the sensory cortex have been developed as means of interrupting the sensory pathways to the conscious centers. However, if drug addiction has been present, these operations do not have the results they would have had if they had been performed earlier.

Procedure

During the years 1981-1983, 178 patients were treated in the Pain Control Center. These patients were referred to the clinic by other physicians because the patient had failed to obtain pain relief. They were willing to accept hypnotherapy as another modality in their treatment. Therapeutic approval consisted of selection of patients in whom the etiology of pain could not be determined by conventional diagnostic tests. It might be assumed

that some of the pain was not organic in origin, but rather was predominantly functional.

Method

Patients were hypnotized using the eye closure method, a quick and relatively simple procedure. The patient sits comfortably in a chair with feet flat on the floor and hands in the lap, palms down. If the hand is warm and slightly moist to the touch, there will be a good response to hypnotic suggestions. If the hand is warm and wet, the patient will be responsive, but is a little nervous. If the hand is hot and wet, the patient will probably fight suggestions. Eye-closure is explained to the patient. Human eyes see in leaps and darts; if they are prevented from following the natural habit of jumping, eye muscles will quickly tire. A sequential approach is utilized for relaxation of the patient.

Competency in hypnotherapy and the self-confidence of the physician tend to assure the patient of the benefits to be derived from hypnotherapy. If the word "hypnosis" is used, there is a tendency for the patient to show slightly increased tension manifested as faster pulse, respiration, and heart beat. This tendency tends to disappear rapidly on subsequent occasions, even without suggestions from the hypnotist. However, these symptoms are neither wanted nor welcomed by patients, and since they can be eliminated prior to the first induction, the therapist should relax each patient prior to the first actual induction without using the word "hypnosis." The physician should always be aware that the patient is conscious and hears and understands everything said to him/her, and should not talk *down* but talk *to* the patient. Words such as "hurt" and "pain" must be avoided. The word "pain" is the most descriptive word in the English language. Suggestive questions as "Does this hurt?" or "Does this pain you?" may actually create pain where there was none before.

The patients in this study were given suggestions for the relief of their discomfort. A total of 550 sessions were used for the 178 patients, and at the third session, the entire procedure was recorded on a cassette tape for the patient, who was instructed to play the tape three times daily, decreasing to two after two weeks, and then to one time after one month. After that, the tape was to be used only when the patient experienced a return of symptoms. The techniques used were the same the patient had experienced during the three therapy sessions.

To assess the efficacy of treatment, a questionnaire was sent to all subjects of the study at intervals

TABLE II
SUMMARY OF RESULTS

	#	%
Questionnaires mailed	178	100
Responses — 6 months	114	64
Pain relief maintained	89	50
Symptoms returned	25	14
Responses — 1 year	89	50
Pain relief maintained	84	57
Symptoms returned	5	2
Responses — 2 years	84	47
Pain relief maintained	79	44
Symptoms returned	5	2
Responses — 3 years	68	38
Pain relief maintained	65	37
Symptoms returned	3	1

of six months, one year, two years, and three years following treatment.

Results

Table II shows the followup summary of results after six months, one year, two years, and three years. Questionnaires were mailed to the 178 patients who had received hypnotherapy for their chronic pain, and who were to be included in the study. Questionnaires were returned by 114 persons (64%), and of these patients, 89 (50% of the study group) reported relief from chronic pain, and 25 (14%) reported that the symptoms had returned during this period and that playing the tapes offered no relief. These patients who had reported pain relief after six months (89) were sent the same questionnaire after one year, and 84 (47%) reported that chronic pain still was relieved by playing the tapes, while five (2%) complained of chronic pain not relieved by hypnotherapy.

Two years after the first treatment, questionnaires were mailed out to the 84 patients who had reported no symptoms of chronic pain after one year: 79 (44%) reported they still had no symptoms of pain, and five (2%) reported symptoms of chronic pain. After three years, 79 questionnaires were mailed, 68 were returned, and of these, 65 still had no complaints of chronic pain (38%). Three patients (1%) had a return of symptoms.

Respondents were questioned about prescription and nonprescription pain medication taken during this period of time, and those who responded stated that nonprescription analgetics were being taken for various symptoms.

Table III illustrates the types of cases and the number of each treated during this period. The ratio of male to female patients was about 2:1. Males

TABLE III
PAIN SYMPTOMS TREATED BY HYPNOTHERAPY

Complaint	# of Patients
Headaches	30
Tic douloureux	8
Facial neuralgia	4
Myositis — thoracic	12
Low back sprain	16
Low back pain (nonsurgical)*	18
Low back pain (surgical)†	15
Sciatica	5
Osteoarthritis (cervical)	18
Whiplash injury	4
Rheumatoid arthritis‡	28
Post-herpetic neuralgia	10
Tennis elbow	6
Vaginal pain	2
Perineal pain	2

* Nonoperative including osteoarthritis, disc, etc.

† Post surgical including post fusion, post discectomy, etc.

‡ Rheumatoid arthritis — hip, shoulder, elbow, hands, etc.

predominantly complained about low back pain, low back sprain, and chronic myositis in the thoracic region. Female complaints were headache, osteoarthritis, and low back pain.

Conclusions

Followup studies on patients who complain of chronic pain are sometimes difficult to obtain. In this series of 178 patients who were referred to the Pain Control Clinic for examination and treatment, 78% were still relieved of their symptoms after six months, 47% after one year, 44% after two years, and 36.5% after three years. Although comparative studies for this period of time were not found, the results seem favorable for the type of therapy the patients received. Of the 178 questionnaires mailed, a total of 28 were returned because of a wrong address or the patient having moved or died. This study was limited to those patients who were selected for the study because of the nature of their complaints. Nonresponders' refusal to participate may be associated with a negative attitude toward the subject investigated, the persistence of the pain, lack of interest in filling out the questionnaire, or a negative attitude toward the sponsor of the questionnaire. These factors may have some effect on the validity of the results. There will be no further followup on these patients because the author has retired from the practice of medicine.

(Continued on page 204)



KANSAS MEDICAL SOCIETY

Newsletter

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JUNE 1987

MEDICAID PAYMENTS SUSPENDED

As a result of serious financial constraints in the Medicaid/MediKan program for the current fiscal year, payments to physicians have been suspended and will not resume until the remittance advice dated June 26, with the corresponding check to be mailed approximately July 6. All claims and adjustments submitted to EDS will be processed, but no reimbursement will be made until after the beginning of FY '88.

AMA DROPS LAWSUIT

Due to recent improvements in the PRO sanction process, the AMA has dropped its lawsuit challenging the process. An agreement that will provide physicians with improved protection was announced jointly by AMA, the American Association of Retired Persons, the Office of the Inspector General, and the Health Care Financing Administration. The AMA will continue to seek improvements in the process through negotiation and legislation.

KDHE & KDOA SECRETARIES APPOINTED

Effective June, the following department heads will assume duties as department secretaries:

KDHE: Stanley Grant, Ph.D., Independence. A certified, professional geologist, Dr. Grant will replace Acting Secretary, Jack Walker, M.D. The Kansas Department of Health and Environment administers all state laws and regulations regarding public health and environmental concerns.

KDOA: Esther Vallodolid Wolf, Lenexa, was named Secretary of the Kansas Department on Aging. Most recently, she was the administrator of the Richard Cabot Clinic in Kansas City. Ms Wolf said she wants to focus attention on services to the frail elderly. She has been researching legislation that would provide for division of assets for elderly couples.

NATIONAL CONFERENCE IMPAIRED HEALTH PROFESSIONALS

OCTOBER 7-11

A wide-ranging program of interest and applicability to physicians who face the spectrum of impairment, not only in their colleagues but their patients as well, will be presented by the AMA in conjunction with ADA, ANA, ABA, APA, AMA Auxiliary and others. The major program component areas throughout this year's conference will be prevention, case-finding, intervention, treatment, referral, aftercare monitoring, and re-entry/re-training. Specialized breakout sessions on the various aspects of impairment as well as for hospital medical staffs and county society programs will also be part of the program.

Please call KMS - 800-332-0156 (235-2383) for a detailed program and registration.

HOME HEALTH DENIALS

The National Association for Physicians in Home Care and 14 U.S. Congressmen have filed a lawsuit against HCFA claiming inadequate supervision of fiscal intermediaries has resulted in inconsistencies and disregard of medical opinions of treating physicians. The suit cites increased denials of payment for home health care. Home health agencies note that the increase in denials occurred at the same time as a 37% increase in hospital patients discharged to home care.

FREE HELPLINE FOR INFO ON DISEASES OF THE AGED

The Kansas Department on Aging provides current information and referrals about diseases of the aged through a toll-free helpline:

1-800-432-3535

1-800-432-3535 statewide
or 296-4986 for Topeka

296-4986 (Topeka)

Professional and family caregivers are encouraged to use the hotline. It is staffed 8 a.m. to noon weekdays; callers may leave messages at other times.

HEALTH DEPARTMENT RELOCATES

The Health Department offices have relocated to the Landon State Office Building (across the street east from the Capitol Building). The new address is 900 SW Jackson, Topeka KS 66620-0001; telephone number 913-296-1240.

NEW BOOK AVAILABLE FROM AMA

A new AMA publication, Physicians' Resource Guide to Health Delivery Systems gives pertinent information about HMOs, PPOs, and other comprehensive reference material. Cost is \$12 for AMA members; \$15 for non-members. Order from the AMA's order department, P.O. Box 10946, Chicago IL 60610-0946; or call 1-800-621-8335.

PLEASE VOLUNTEER AND DO YOUR PART

Dr. Hatton, KMS President, has appointed the following committee chairmen:

Aging - Arthur D. Snow, Jr., M.D., Shawnee Mission

CME - James J. Bergin, M.D., Kansas City

Credentialing - Deloris W. Bell, M.D., Shawnee Mission

EMS - Robert A. Worsing, Jr., M.D., Wichita

Health/Environment Liaison - Richard Meidinger, M.D.,
Topeka

HMSS - Richard B. Darr, M.D., Shawnee Mission

Impaired Physicians - Timothy M. Scanlan, M.D., Wichita

Maternal Health - Henry W. Buck, Jr., M.D., Lawrence

Membership/Insurance - Linda D. Warren, M.D., Hanover

Nominating - Franklin G. Bichlmeier, M.D., Kansas City

Professional Liability/Legislative - Jimmie A. Gleason,
M.D., Topeka

Professional Practices Review - Newton C. Smith, M.D.,
Arkansas City

SRS Liaison - Phillip A. Godwin, M.D., Lawrence

If you are interested in serving on any one of the committees, please so advise the Chairman or the Executive Office by July 10. This is necessary so that accurate information can be printed in the Roster, which will be going to press at that time.

HOSPITAL PROFITS RISE

According to Congressional Budget Office estimates, profits realized by hospitals on the treatment of Medicare patients were at least 17.6% and 15.7% in 1984 & 1985 respectively. This compares with 12-15% in 1984, the first year during which payments were based on the DRG system. The number of Medicare patients has declined, but the profits are attributed to such factors as success by hospitals in containing costs, reduction in length of hospital stay, and errors in determining the payment scale.

THE ANATOMY OF A PATIENT RECORD

Effective May 1, 1987, a Board of Healing Arts regulation takes effect that specifies what constitutes a patient record:

1. It is legible;
2. it contains only those terms and abbreviations that are comprehensible to similar licensees;
3. it contains adequate identification of the patient;
4. it indicates the dates any professional service was provided;
5. it contains pertinent and significant information concerning the patient's condition;
6. it reflects what examinations, vital signs and tests were obtained, performed or ordered and the findings and results of each;
7. it indicates the initial diagnosis and the patient's initial reason for seeking the licensee's services;
8. it indicates the medications prescribed, dispensed or administered and the quantity and strength of each;
9. it reflects the treatment performed or recommended; and
10. it documents the patient's progress during the course of treatment provided by the licensee.

Patient records are to be maintained by each licensee of the Board or the licensee's designee for a minimum of ten years from the date any professional service was provided.

KMS CME ACCREDITATION CONTINUED

The Accreditation Council for Continuing Medical Education has awarded the KMS CME Accreditation Program continued recognition for a period of four years. The Committee for Review and Recognition congratulated the Kansas Medical Society for its efforts and leadership in providing this service.

FLYING PHYSICIANS

JULY 13-17
SANTA FE, NEW MEXICO

The Flying Physicians Association, Inc., will convene their 33rd Annual Meeting in Santa Fe, New Mexico, July 13-17. Topics for the scientific sessions will include Heart-Lung Transplantation, Prenatal Diagnosis of Pediatric Surgical Disease, and Update of Diagnosis & Treatment of Peptic Ulcer Disease. CME credit is available for these sessions. For information, contact Carol Laurie, 816-966-4003.

KANSAS TEEN BIRTHS '85

In 1985, 1,477 girls 12-17 years of age gave birth; of these, 139 were second babies, 15 were third babies, and two were the fourth babies for these teen-age mothers. Ages of the fathers are known in 847 cases, and 436 of them were at least 20 years old. (From the Kansas Department of Health & Environment)

HEALTH & VDTs

The AMA has recently reviewed the literature concerning the effects of radiation from video display terminals on human health. The report, published in JAMA 1987;257(11), points out that the radiation from VDTs is almost undetectable and cannot because such health problems as spontaneous abortions, birth defects, and cataracts in VDT operators. Some other complaints, such as musculoskeletal disorders, may result from work station conditions and environment that can be remedied to better accommodate the operator.

SALINA NEUROLOGIST PUBLISHES BOOK

James W. Neumann, M.D., Salina, is the author of a recently published book entitled Listening to Your Own Body: A Guide to the Neurological Problems That Afflict Us as We Grow Older. The book, published by Adler & Adler, \$14.95, acquaints the reader with symptoms that can help to identify neurological illnesses in early stages. The book is available from Downtown News or Waldenbooks in Salina, or ask your local bookstore to order it from the publisher.

A FAMILY GUIDE TO ALZHEIMER'S

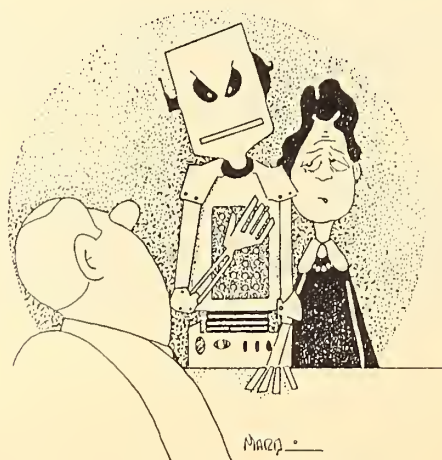
A Family Guide to Alzheimer's Disease is available from the Washburn University bookstore for 75¢. This brief review is intended as an introduction to the diseases processes for caretakers of ill family members or friends. It includes referral information to services and agencies that are pertinent to AD, and may be of assistance to patient and caretaker. Contact the bookstore at 913-295-6349 or c/o Washburn University, Topeka KS 66620.

BECKER APPOINTED CHAIRMAN

Karl E. Becker, Jr., M.D., has been appointed chairman of the Department of Anesthesiology at the University of Kansas School of Medicine-Wichita. Dr. Becker is professor and clinical assistant professor, respectively, in Anesthesiology and Pediatrics, and currently serves as director of Anesthesia Education at HCA Wesley, St. Francis, and St. Joseph Medical Centers and director of Anesthesia at the Plastic Surgery Center, all in Wichita.

MEDICAL ASSISTANCE DEGREE TO BE OFFERED

Kansas Newman College, Wichita, has announced plans to implement a one-year degree-completion program for medical assistants who have earned their C.M.A. The course will consist of 30 hours of college credit that will apply toward an Associate of Science in Health Science degree, and it is expected to be in place by September 1988. After one year of operation, AAMA accreditation for this program will be sought. The basic courses required for CMA credentialing are currently available at Kansas Newman.



"Well, here's our Medicare billing robot that's been programmed with your maximum allowable actual charges . . . We've nicknamed it 'MAAC the knife.'"

--Reprinted with permission from American Medical News and cartoonist Don B. Marquis.

Male Contraception and AIDS Prevention

The Need for Involvement by Kansas Physicians

M. BROWN, R.N., B.S.N., *Topeka*

HETEROSEXUALLY ACTIVE males have helped to increase the percentage of all Kansas live births that are out of wedlock. Every year since 1959, when it was about 2%, it has risen to approximately 15% (5,818 of 39,418 live births) in 1985.¹ Nationally, more than 600 adult or adolescent males have contracted incurable and usually fatal acquired immune deficiency syndrome (AIDS) through heterosexual contact; through sexual contact, males have given human immunodeficiency virus (HIV) to more than 600 adult or adolescent females who subsequently developed AIDS.¹

Kansas physicians need to assume an active role in the development of procedures to convince heterosexually active males to practice abstinence and other responsible reversible birth control, and to help the U.S. Surgeon General to persuade such males to practice abstinence and other AIDS prevention more than they do at present.² Kansas physicians can utilize their professional authority and personal credibility to assist in educating males on how to choose the best contraception and AIDS prophylaxis methods as well as how to *always* use those methods most effectively.

Background

Kansas needs to improve public policies for the prevention of chronic serious problems related to human reproduction. Females are the focus of almost all birth control efforts, contraception research, and testing of related theories.³⁻⁵ Yet thousands of Kansans annually are joining the ranks of those who are forced to rely heavily on public financial, mental health, and related assistance as a result of pregnancies that were quite possibly unintended.¹ The common outlook for pregnant girls 17 years old or younger, pregnant women past their mid-thirties, marriages following out-of-wedlock pregnancies, and families headed by unmarried females includes the increased possibility of major disappointments.⁶

In 1985, heterosexually active males helped Kan-

sas girls 12-17 years old have 1,477 babies; of those teen and preteen new mothers, 139 (including one 14 years old or younger) had their second babies, 15 had their third babies, and two had their fourth babies. For older Kansas females that year, one who was 18-19 years old had her sixth baby, two who were 20-24 years old had their eighth babies, and one who was 25-29 years had at least her tenth baby. The ages are known for 847 of the males who fathered babies with the 1,477 girls 12-17 years old, and 436 (51%) were at least 20 years old.¹

In 1985, couples' products of conception were electively aborted for 4,645 Kansas females, including 619 teen and preteen girls 12-17 years old. These abortions involved 516 females during the 14th week of gestation or later, and 114 females for whom it was at least their fourth induced abortion.¹

In a related vein, AIDS has become an obvious major health threat to Kansans, including heterosexuals. The number of Kansans diagnosed with AIDS during the last three years increased from only two in 1984, to 14 in 1985, to 37 in 1986. Kansas has had AIDS cases contracted through heterosexual transmission in both directions; one very young Kansas child who has AIDS is assumed to have been infected prenatally. Sixty-two per cent of Kansans diagnosed with AIDS during 1986 had died by April 13, 1987.¹

Since there is no AIDS vaccine, the AIDS problem is serious on a national as well as state basis. Almost 400 infants have contracted AIDS through prenatal infection, and they will probably soon become orphans and die not long after that.¹ Most of the estimated 1-2 million Americans infected with HIV have not developed AIDS, but can nevertheless infect others.² Almost anyone infected with another sexually transmitted disease (STD) theoretically can also be infected with AIDS since all STDs, by definition, are spread in a similar manner, and the AIDS incubation period can be as long as nine years.² In 1985, for example, 699 Kansas children 3-17 years old were treated for gonorrhea.¹

Effective Male Contraception

Kansas physicians can help to assure that heterosexually active males, especially those 17 years old or younger and those whose female sex partners are 17 years old or younger, are fully aware of the obvious high contraceptive effectiveness of abstinence as well as their own consequences if their partners have unwanted pregnancies. Nonprescription condoms lubricated on the inside and outside with nonoxynol-9 spermicidal agent had a user failure rate of less than 1% (0.83%) in a study done in 1975. This is less than one-tenth of the 10% user failure rate of nonspermicidal condoms and less than one-half of the 2% user failure rate of widely-used birth control pills. The term "user failure rate" means that for each 100 ordinary users of a specific contraceptive method, the number of pregnancies that will usually occur for those 100 people by the end of the first year of use will be ____(%). Abstinence, condoms, and spermicides carry virtually no risk as compared to birth control pills, intrauterine devices (IUDs), legal induced abortions, and illegal induced abortions.⁶

Effective AIDS Prevention

Kansas physicians can actively advocate abstinence and other "safe sex" practices as elucidated recently by the U.S. Surgeon General.² Investigators, including several from the U.S. Public Health Service's Centers for Disease Control and National Institutes of Health, obtained research results that strongly suggest that condoms and the spermicidal agent nonoxynol-9 independently prevent the spread of AIDS.⁶⁻⁹ Those two AIDS-prophylaxis methods also protect well against incurable herpes and many other major and minor STDs capable of producing grave complications such as sterility.^{6, 7, 9} Since 1982, condoms precoated on the inside and outside with a lubricant containing nonoxynol-9 have been marketed in the United States. Physicians can, for example, encourage couples to have the male partner use a spermicidal condom while the female partner uses vaginal foam containing nonoxynol-9 to increase the condom's protection and serve to reinforce STD prevention in case the condom breaks, slips off, or otherwise fails.⁶

Preventive Initiatives

Studies of male birth control and public health recommendations on AIDS prophylaxis indicate approaches that physicians may employ to help increase use of appropriate reversible contraception and STD prophylaxis by heterosexually active males,

including several target groups.^{2-5, 10, 11} For instance, physicians can help arrange for appropriate posters, brochures, and other patient education materials to be located in or near men's restrooms and locker rooms and offered to university men's dormitories and fraternities, fraternal organizations, men's church groups, women at family planning facilities, and perhaps senior and junior high school students by their parents or with their parents' consent. Physicians can encourage pharmacists who work in drug stores to actively promote public awareness of the noteworthy contraception and AIDS-prophylaxis efficacy of various combinations of abstinence, condoms, spermicides containing nonoxynol-9, and condoms prelubricated with a spermicide containing nonoxynol-9. Recommendations in the previously noted male birth control studies and in AIDS prevention literature suggest other promising approaches that can be employed by physicians.

Summary

Kansas physicians, by promotion of abstinence and other reversible male birth control, can assist in preventing males from helping to produce unintended infants born to teenagers, preteenagers, and single women who genuinely do not yet want to become parents.⁶ Physicians can simultaneously help to reduce the spread of deadly AIDS and many other major and minor STDs that otherwise can be expected eventually to touch their own patients, friends, and relatives.

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Aggressive Early Management of Postinfarction Myocardial Rupture

ZACK A. RAZEK, M.D.* and WILLIAM HAYES, M.D.,† *Wichita*

THE SURVIVAL rate of patients with myocardial infarction continues to rise with improved methods of management. Acute pump failure however continues to be the leading cause of death in hospitalized patients with acute myocardial infarction.¹ Myocardial rupture is the second most frequent cause of acute pump failure and accounts for a disproportionately high percentage of deaths.² A high index of suspicion and aggressive medical-surgical intervention may improve the outcome for these patients.

Isolated reports of repair of ventricular rupture in the setting of acute myocardial infarction appear sporadically in the literature. The following case report demonstrates early surgical intervention.

Case Report

A 60-year-old white female with a history of recent onset angina of several weeks duration was admitted to the acute coronary care unit at Wesley Medical Center on May 25, 1986, with the EKG diagnosis of acute inferior myocardial infarction. On admission she was stable; blood pressure 140/95, pulse 56/min, and respirations 16/min. She had no murmurs and no evidence of failure. Her total creatinine phosphokinase (CPK) was elevated with 33% MB band and rose to 2960 IU/l (normal 38-224). She was treated in a conventional manner. On the second day she developed a loud pericardial friction rub with associated pleuritic chest pain. There was no murmur, no evidence of jugular venous distension (JVD), or paradoxical pulse. Her BP was 110/80, pulse 84 and regular. She was treated with Indocin in addition to sedatives (meperidine hydrochloride and acetylsalicylic acid). She improved clinically, and the friction rub was not au-

dible the next day. The patient was then transferred to the intermediate coronary care unit.

The evening of the fourth day she developed recurrent chest pain requiring meperidine hydrochloride sedation. EKG and physical examination were unchanged. Several hours later she fainted while walking to the bathroom. Blood pressure was not obtainable, EKG showed sinus bradycardia with a rate of 20. Cardiopulmonary resuscitation was instituted with volume expansion and dopamine hydrochloride intravenously. She regained consciousness but remained hypotensive and became tachycardic. A Swan-Ganz monitoring catheter was inserted and intra-aortic balloon counterpulsation was instituted with little response in her blood pressure. On fluoroscopy at balloon insertion, the cardiac shadow appeared still, and the diagnosis of ventricular rupture was entertained.

The patient was taken to the cardiac catheterization laboratory for study but appeared moribund, and a decision was made to proceed with operation without catheterization. In the operating room the patient was quickly prepared. When the pericardium was incised, a total clot cast of the pericardium was seen and the patient's blood pressure improved dramatically. Cardiopulmonary bypass was instituted, the clot was removed, and the large area of the inferior wall infarction was noted. Two slit-like lacerations about two inches in diameter were seen in the center of the infarcted area. The right coronary artery was heavily calcified to the crux and supplied the area of the infarct. Palpation revealed placquing in the proximal left axis deviation (LAD) and the circumflex arteries. Repair of the lacerations without infarctectomy was performed. Two aortocoronary bypasses to the LAD and circumflex with reverse saphenous vein were also done.

Her postoperative hospital course was essentially uneventful except for two episodes of ventricular fibrillation eight days postoperatively. She was successfully defibrillated. At the time of discharge she was feeling good. The examination of her heart was within normal limits; BP was 100/60, pulse was 96/

(Continued on page 205)

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Health Care Stewardship

FRANCIS E. CUPPAGE, M.D.*; MARCIA WRONA, B.S.W.† and
RUTH HASSANEIN, Ph.D.,† *Kansas City, Kansas*

HISTORICALLY society has considered the physician and nurse as benevolent healers, angels of mercy, and sage citizens. More recently allied health care providers have joined these "sacred" ranks. In taking the Oath of Hippocrates, physicians profess to lead lives of uprightness and honor, seeking to heal the sick and prevent disease. Recently, this public image and perceived esteemed role has been challenged by a constellation of circumstances that include professional competition, legalism and malpractice litigation, advanced technology, escalating costs of health care, and depersonalization of patient-physician relationships.

A unique role of the physician in the charitable stewardship of societal resources has been suggested.¹ It has been suggested that the attributes of the physician, and presumably other health care providers, include intelligence, breadth of education and humanitarian concern, all of which enable these individuals to participate in societal stewardship through involvement in politics, religion, education, ethics, welfare, and community affairs. With the possible changing patterns of the selection of medicine as a profession, the education of the physician and the subsequent practice of medicine, one might question whether these health care providers do provide a unique stewardship role to society.

This study was undertaken to evaluate existing patterns of stewardship by health care providers, both educators and practitioners, in a selected population in a midwestern metropolitan area. While stewardship has been defined as management of property and financial affairs of others, for the purpose of this study the term has been used to describe the charitable donation of time, talent, and money by the health care professional for the betterment of society. Although various health care professionals were included, the major focus is upon the

physician. We chose to evaluate these roles by means of a questionnaire distributed to faculty members and to a random sample of practitioners. We compared stewardship characteristics of these groups, with respect to donation of both time and money. The evaluation of the returned questionnaires suggested several interesting patterns of societal stewardship which will be presented and discussed.

Methodology

Setting and Subjects

The study took place in January 1985 in a large midwestern metropolitan area. Subjects were selected from two major populations:

1. Faculty members of three health-related schools in a large medical center — Allied Health, Medicine, and Nursing.
2. Health care practitioners who comprised the mailing list for the Division of Continuing Education of that large medical center.

In the first group the questionnaire was mailed to the total sample of 550 faculty members. In the second group a 20% random sample of the 3,191 professionals on the mailing list was selected, and the Service Questionnaire was mailed to 638 individuals.

Questionnaire

The survey instrument, titled the Service Questionnaire, was developed by the authors to evaluate stewardship activities as categorized previously by one of the authors (FEC). Specifically, two forms of stewardship — donated time and money — were studied. The following seven categories of stewardship were included: professional organizations, educational organizations, political and governmental activities, community and neighborhood activities, religious organizations, consumer advocate activities, and ethical/moral advocate activities. An eighth, open-ended category was included for additional activities. Within each category, specific items were listed as examples to facilitate response. For each item respondents were asked to indicate (1) the approximate total number of hours per year

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TABLE I
AGE AND EDUCATIONAL LEVEL OF
RESPONDENTS

Age (years)	Number	(%)
20-29	17	(5.5)
30-39	100	(32.5)
40-49	82	(26.6)
50-59	65	(21.1)
60 and over	37	(12.0)
Unstated	7	(2.3)
Total	308	(100.0)
<i>Educational level</i>		
Certificate or Bachelors	11	(3.6)
Masters	49	(15.9)
Doctorate	243	(78.9)
Other or unknown	5	(1.6)
Total	308	(100.0)

spent on this activity, and (2) the approximate total number of dollars per year spent on the activity. For the purpose of data analysis the number of hours and number of dollars were summed across all items in each category.

The questionnaire also solicited demographic information that included the respondent's gender, age, terminal degree, and primary professional responsibility, *i.e.* faculty or private practitioner.

Statistical Analysis

Data were entered into a NAS 8043 mainframe computer and analyzed using the software packages BMD-P (1983 revision) and SAS (release 82.3). In addition to numerous descriptive and graphic procedures, the technique of stepwise multiple regression was utilized.

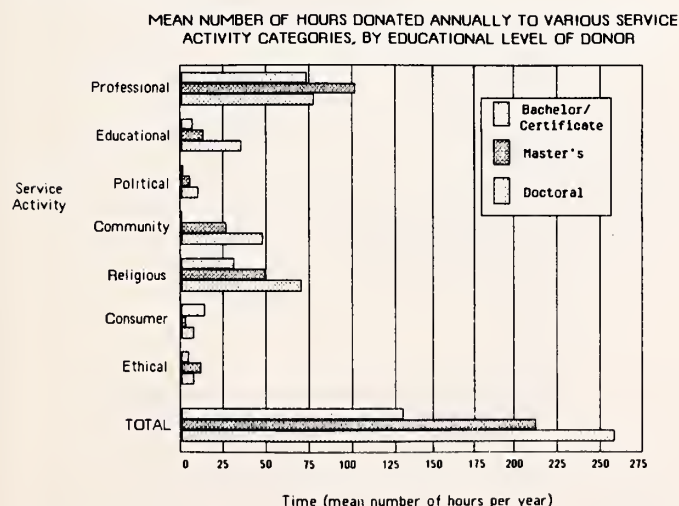


Figure 1. Hours of time donated for various service activities by educational level of donor. Increased donated time is noted as educational level increases.

Results

Respondents

Questionnaires were mailed to a 20% random sample of the 3,191 practitioners in the community. Responses were received from 78 individuals of the 638 surveyed. From the 550 faculty members to whom questionnaires were sent, there were 247 respondents. From these 325 responses, 17 questionnaires were deleted because of missing data. Thus the following analyses were based on a final sample total of 308 individuals.

Characteristics

The gender distribution of the subjects was 64.5% male and 35.5% female. Approximately 75% of respondents were faculty members and 22% were private practitioners. Ten individuals reported that they were "both." Such individuals were assumed to be voluntary faculty and therefore were classified as private practitioners. Age distribution and educational level of subjects is shown in *Table 1*.

Data Analysis

To evaluate the patterns of stewardship demonstrated by the respondents to our Service Questionnaire, we wished to determine which characteristics of the subjects predicted the quantity of stewardship activity. Specifically, we were interested in which demographic variables were significantly related to the outcome variables of donated time and money. These outcomes were selected because they are traditionally associated with stewardship, and they are quantifiable.

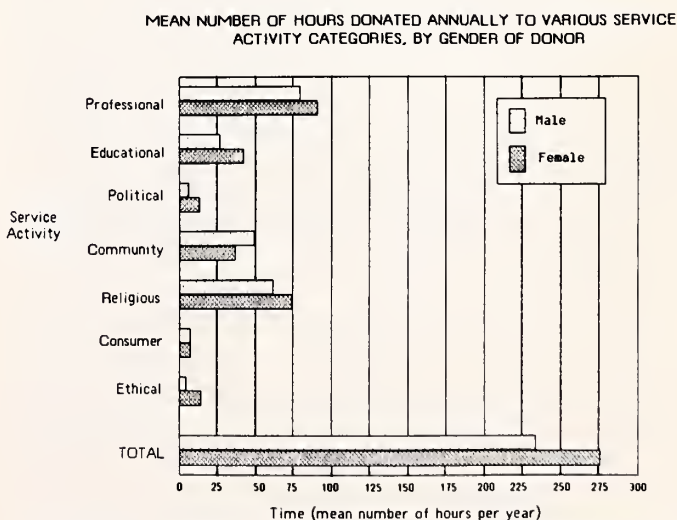


Figure 2. Hours of time donated for various service activities by gender of donor. Increased donated time is noted by female gender when all service activities are considered together.

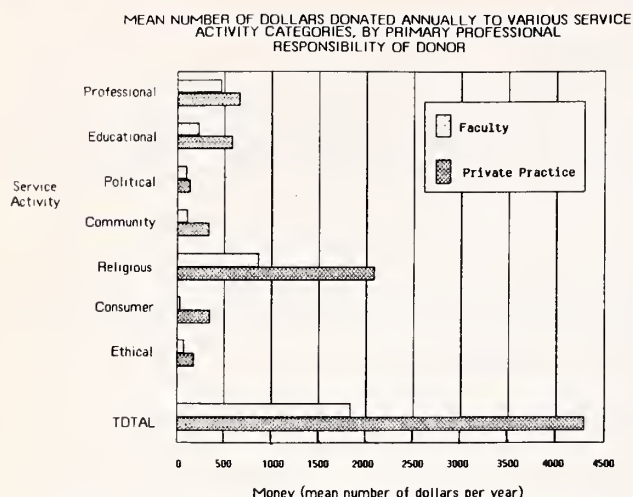


Figure 3. Mean amount of money in dollars donated annually to various service activities by primary professional responsibility of donor. Private practitioners donate a significantly greater amount of money than faculty.

The statistical method of stepwise regression analysis was utilized. This type of multivariate analysis is useful when one or more of a number of potentially intercorrelated independent variables may predict a single dependent or outcome variable. In our study, the independent variables were age, gender, educational level, primary professional responsibility (faculty vs private practitioner), and professional category (physician vs non-physician). The dependent variables were the measures of stewardship, *i.e.*, amounts of donated time and money. The stepwise regression analyses were run separately for each of the two dependent variables.

Results of the stepwise regression analyses indicated that two of the independent variables were significantly predictive of the total amount of donated time. These were educational level and gender. The findings indicated that the amounts of time donated to service activities were significantly greater as the level of education increased, and that females donated significantly more time overall than males. These relationships are displayed graphically in Figures 1 and 2. Although the figures depict the individual activity categories as well as the totals, the statistical analysis focused upon the totals only. The stronger of the two variables in predicting amount of donated time was educational level, although both variables were statistically significant. In predicting time donated, the other three variables were found not to be statistically significant predictors once educational level and gender had been considered.

However, these other three independent variables — age, faculty vs private practitioner, and physician vs non-physician — were each significantly predic-

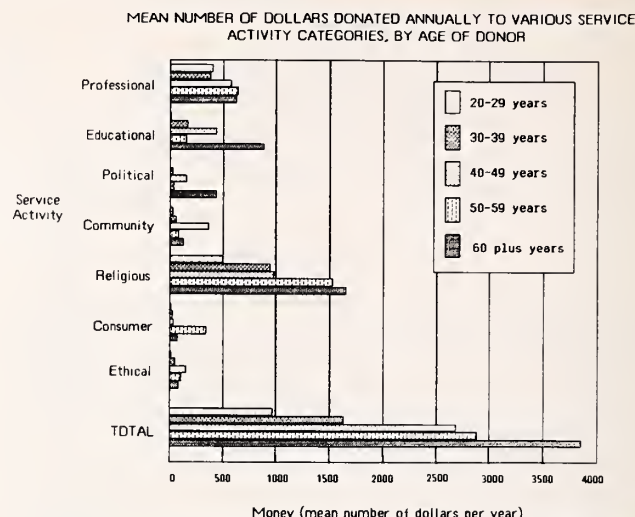


Figure 4. Mean amount of money in dollars donated annually to various service activities by age of donor. Generally donors of greater age give more dollars.

tive of the other dependent variable, amount of money donated. The strongest of these was the faculty-private practice dichotomy. Faculty members contributed significantly fewer dollars than their colleagues in private practice (Figure 3). The independent variable of age then entered the predictive equation, with significantly greater amounts of money being donated as the age of the respondents increased, as demonstrated in Figure 4. Finally, after all other variables had been considered, the variable of physician vs non-physician came into play. Physicians were found to contribute significantly more dollars than their non-physician counterparts in the health professions (Figure 5).

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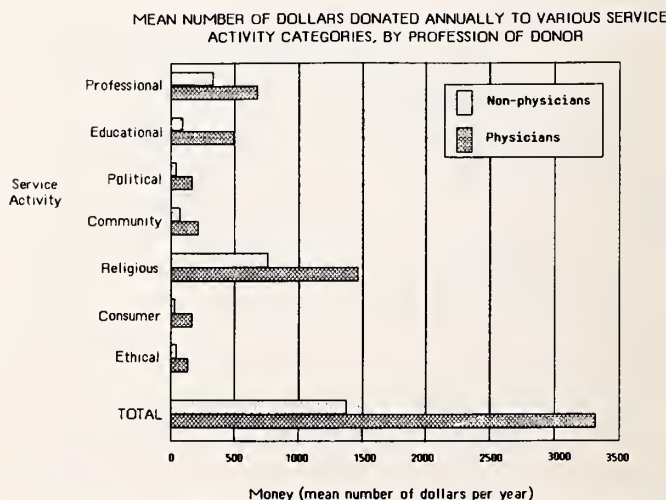


Figure 5. Mean amount of money in dollars donated annually to various service activities by profession of donor. Physicians donated significantly more money in all categories than non-physicians.

PRESIDENT'S MESSAGE

THE MEDICAL PROFESSION has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The AMA has published, in its *Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association*, Standards of Conduct that define the essentials of honorable behavior for the physician. For those who do not have or who have not read a copy of the *Current Opinions*, I recommend that they do so.

In my address to the Second House of Delegates in May, I outlined some of the qualities that I recognize in a professional. First, a professional is identified by having and being able to apply a body of knowledge not held by others. Second, the professional must be able to assess his/her performance and change behavior based upon the analysis of that performance. Third, the professional holds the needs of others above his/her own needs.

When the profession is criticized by those outside the medical profession, having a set of ideals and principles close at hand and operational can only strengthen our resolve and justify our stand. Many problems are before us and many decisions will need to be made, not only in our own day to day work, but in legislative action. Having a code will make our work easier.

Our concern should be foremost for our patients, and our resolve that of quality medical care. Dr. Wallace J. Mulligan, F.A.C.P., in *The American College Physician Observer*, wrote his opinion concerning the myth of the ideal internist. He recognizes the fact that the ideal internist that he used to



look for does not exist because he sought perfection, and perfection doesn't exist in human functioning. He comments that he now recognizes the ideal internist as one who does his/her best.

We all need help, and studying the *Current Opinions* and recommitting ourselves to our standards of conduct can affirm our oath to do our best.

A handwritten signature in dark ink, reading "Donald V. Hutton M.D." with a stylized flourish at the end.

President

EDITORIAL COMMENT

Uncertain Certainties

The trouble with people is not that they don't know but that they know so much that ain't so. — Josh Billings.

IT HAS LONG SINCE been apparent that this page lives in a constant state of wonder at the technologic activities of medical practice of the day — not to mention the ethical and philosophical dilemmas they produce. Half a century ago, we scarcely dreamed of the current commonplaces — or the derivative problems which would follow the accomplishments. The process of conquering one condition or question produces more to take its place. The victors, as always, become the victims.

In every age, such changes and their effects produce in the seniors (L., *senex*, gen. *senis*; cf. L. *senesco*, state of growing older, as in “Darling, I am growing ~”) reactions ranging from aggressive to defensive. The aggressive approach is exemplified by a claim to understanding what is going on, actually a form of intellectual cosmetic surgery with the hope that the result will suggest a youthful state although the internal substance isn't really changed. The defensive attitude expresses itself in rambling responses to questions in the hope they will be interpreted as erudition.

If our juniors seem to assimilate the new more readily, this can be accounted for by the fact that they have more storage room on their cerebral floppy disks — they don't have to wipe out some “truths” from the past to accept the new. Do they know irradiation of the thymus for unexplained respiratory distress in the newborn? Do they dare irradiate the ovaries of infertile women to “help” them conceive? There was a time, too, when it was certain that sweepings off the mill floor were fit only for barnyard animals, not for the delicate human bowel. The fear of “autointoxication” and this dread of excessive roughage led to fortunes in Sal Hepatica and Fleet's Phospho-Soda. Today, it is the cereal companies and health food stores that are making hay — a good word in this case. An even earlier recollection is of the grim and fully-believed statement of the respected college chemistry professor who assured us if anyone *did* split the atom, the consequent chain reaction would destroy the world

(perhaps a case of being right but in the wrong context — so far).

Still, with senile stubbornness, we wonder if medical practice has really changed as much as is presumed (and we have bemoaned on various occasions). Admittedly, our claims for the virtues of the past are often self-serving, but what has been the net profit from the endless variety of new methods and standards? We have certainly complicated things and the market place costs have produced whole new concepts of service and remuneration. This monetary yardstick in itself, even allowing for inflation, measures one of the more apparent forms of comparison with the past and calls into question not only the product from the medical dollar but the resulting question, the value to society for that investment. Can we, for example, reduce expenditures on the one hand and yet continue to provide care in the manner it has now reached — and prompts its supporters to raise loud objections whenever curtailments are proposed?

Whatever impact the medical marvels have had on society, whatever the cost in material terms, whatever visions for the future it may foster, one obvious change in the medical zoo and its inhabitants has been in the variety of housing alterations. The former individualistic basis of location, decision, and execution of medical service applying to both physician and patient (although never as purely as we like to think) is giving way to a communal form of medical production. This is increasingly across the board — physician officing and staffing, intraprofessional relationships, treatment sources, methods and locations, and certainly the financial and legal structures which have moved from supporting to controlling.

The practice of medicine will be different but that is as it should be. It is always changing. The young see things differently. That is not only as it will be but as it has always been. It is as though medicine is in a state of perpetual adolescence — painful readjustments (especially to the puzzled parents). It is as though it (and we) never reach full maturity — but that is as it should be. Beware of those who think they have. — D.E.G.



MEDICINA ET LEX

May the Health Care Stabilization Fund Settle a Claim Over a Physician's Objection?

WAYNE T. STRATTON, J.D.,* *Topeka*

THE FOREGOING QUESTION was answered in a decision of the Kansas Supreme Court issued on March 27, 1987. In this case, a Kansas physician believed quite strongly that his malpractice insurance carrier should have not settled a claim and objected to the Health Care Stabilization Fund contributing to a settlement. Despite his objections, the trial court approved the settlement.

Upon appeal, the Kansas Supreme Court discussed the relationship of a physician to the Fund. The Supreme Court concluded that "a defendant has no constitutionally protected right to require that a plaintiff's action continue for the sole purpose of allowing the defendant to vindicate himself."

Respecting the due process right, the court observed that the Act requires a physician to maintain professional liability insurance as a condition of rendering services in the state. The terms of the insurance policy contained an agreement that the physician's insurance company could defend or settle any claim covered by the policy without the consent of the doctor. In the case in question, the insurance carrier chose not to defend the claim but agreed to settle its liability to the claimant within the policy limits and notified the Fund of its intention. The Insurance Commissioner was then entitled to negotiate an amount to be paid from the Fund as a settlement or continue to defend the action.

The court noted that the Act, unlike an insurance policy, contains no explicit waiver or consent provision that allows the Fund to settle the action with the claimant without the consent of the health care



Mr. Stratton is legal counsel for the Kansas Medical Society. His discussion topics are selected for their medicolegal interest to physicians. Readers are invited to submit questions or items of interest in this area for attention in this series.

provider, but concluded that it was implicit in the Act that the provider relinquish his right to prevent a settlement. "To allow physicians to control the defense of malpractice claims against them and reach their own decisions to continue or to settle the action would undermine the whole purpose and the financial structure of the Act."

The court noted that under the procedural framework of the Act, a health care provider is given the opportunity to represent his/her interests to the court at the settlement hearing, thus maintaining procedural due process rights under the Act.

The court stated that there is no individual due process right where the state has a countervailing

(Continued on page 205)

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE or the Kansas Medical Society. For further information, contact Mr. Stratton, 215 E. 8th, Topeka KS 66603; 1-800-332-0248.

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Stewardship

(Continued from page 198)

Discussion

The present study originated from the concepts previously postulated by one of the authors (FEC) that stewardship should be an important characteristic of physicians and that, by the nature of their background and training, physicians should have the propensity for stewardship.¹ Stewardship, defined as the management of the property or financial affairs of others, implies the charitable donation of time, talent and money, for the betterment of society. In the recent past physicians were held in great esteem by the public in part because of their caring nature. The idealist might suppose that most physicians would readily give of themselves both in time and money for the betterment of their patients and society as a whole. On the other hand, the cynic might believe that because physicians care for the sick on a daily basis they might be unwilling or unable to give further of themselves and thus not qualify as good stewards.

The purpose of this study was to evaluate the stewardship of time and money given by physicians as compared with other health care professionals including both practitioners of health care as well as faculty members who train these practitioners. For this purpose, the Service Questionnaire was developed with independent variables of age, gender, educational level, and primary professional responsibility (practitioner vs faculty). The dependent variables were the measures of stewardship — donated time and money. Categories of stewardship evaluated included professional organizations, educational organizations, political and governmental activities, community and neighborhood activities, religious organizations, consumer advocate activities, and ethical/moral advocate activities. No significant distinctions resulted from the evaluation of individual categories; therefore, all categories were summated and discussed as the total of all stewardship activities.

The results indicated that all of the independent variables were predictive of either donated time or money. Educational level and gender were predictive of time; while age, faculty vs practitioner, and physician vs non-physician health care professional were found to be predictive of the amount of money donated. None of the independent variables were predictive of both time and money.

As the level of education increased from certificate through doctoral, more time was donated to-

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ward stewardship activities by all health care professionals. We were interested to find greater amounts of donated time among the most highly educated, which may be due to the increased demand in our society for the service of an "expert." Most professionals who fit this definition would be expected to have the highest levels of education.

The finding that females donated significantly more time to service may be due to simple societal role expectations. In addition a large proportion of the women in the faculty group were from the nursing profession, whose dedication to service is expected. Of interest is the fact that there was no statistically significant difference between physicians and non-physicians in time donated. This could be interpreted as a lack of desire to donate time on the part of the physicians. On the other hand physicians are usually extremely busy but still manage to give as much time as non-physicians, thus supporting the concept that physicians do contribute to stewardship by donating their time.

When the stewardship activity under consideration was donated money in dollars, we found that the strongest significant prediction of this activity was whether or not the health professional was on the faculty or in private practice, with faculty contributing fewer dollars to stewardship activities. Given the smaller incomes of this group, this finding was not surprising.

Of great interest was the finding that the level of financial donations increased nearly linearly with age. While this may simply reflect an increased earning capacity as the individual increases in age, it may also be indicative of a more positive attitude toward stewardship in the older generation, as depicted by the large increase in dollars given by those age 60 and older (*Figure 4*). The desire for tax deductions and release from an expensive educational demand for children may be additional contributing factors to this increased charity with age.

After both of the two variables discussed above had been taken into account, it was found that when donated money was evaluated, physicians gave significantly more than non-physicians. While this may be related to higher incomes, it may also suggest that physicians are simply willing to give more of their earnings to society. This finding is in contrast to those impressions published by Musher, who considered a complex set of physician rationaliza-

tions to explain his experience of a lack of money donated to charities.²

The results of this survey suggest that physicians and other health care professionals give a considerable amount of both time and money for various stewardship activities. One must be careful in generalizing, however, because the returned sample from practitioners was relatively small and may not be truly representative of the stewardship of practitioners on the whole. The larger response rate from faculty may be related to familiarity of the faculty with the authors.

We feel that stewardship of time and money is a desirable trait for health care professionals. Public image of the health care professional is an important quality in the provision of health care. Ideally, health care providers, and especially physicians, should be recruited into these medical fields because of virtuous traits.³⁻⁵ We feel that health care professionals who practice societal stewardship are more likely to provide quality health care than those not involved with humanitarian concerns.

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Hypnotherapy

(Continued from page 192)

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ZANTAC® 150 h.s.

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In two randomized, double-blind, and well-controlled clinical trials, ZANTAC 150 mg h.s. significantly superior to cimetidine 400 mg h.s. for maintenance therapy in healed duodenal ulcers.

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USA ¹	ranitidine 150 mg h.s.	9%	14%*	16%†	60
	cimetidine 400 mg h.s.	23%	34%	43%	66
UK, Ireland, Australia ²	ranitidine 150 mg h.s.	8%‡	14%‡	23%‡	243
	cimetidine 400 mg h.s.	21%	34%	37%	241

*p=0.02

†p=0.01

‡p<0.004

%=life-table estimates

All patients were permitted prn antacids for relief of pain.

These two trials used the currently recommended dosing regimen of cimetidine (400 mg h.s.) and ranitidine (150 mg h.s.). A comparison of other dosing regimens has not been studied.

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Brief Summary of Product Information.

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References:

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3. Data available on request, Glaxo Inc.

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INDICATIONS AND USAGE: ZANTAC[®] is indicated in:

1. Short-term treatment of **active duodenal ulcer**. Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer**. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD)**. Symptomatic relief commonly occurs within one or two weeks after starting therapy and is maintained throughout a six-week course of therapy.

In active duodenal ulcer, active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC[®] is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: Symptomatic response to ZANTAC[®] therapy does not preclude the presence of gastric malignancy.

Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see **DOSE AND ADMINISTRATION**). Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

False-positive tests for urine protein with Multistix[®] may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Although recommended doses of ZANTAC do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Lack of experience to date precludes recommending ZANTAC for use in children or pregnant patients. Since ZANTAC is secreted in human milk, caution should be exercised when administered to a nursing mother.

ADVERSE REACTIONS: Headache, sometimes severe, seems to be related to ZANTAC[®] administration. Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

In normal volunteers, SGPT values were increased to at least

twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

There have been rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdose and its treatment appears in the full prescribing information.

DOSE AND ADMINISTRATION: Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison Syndrome): The current recommended adult oral dosage is 150 mg twice a day. In some patients it may be necessary to administer ZANTAC 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg twice a day.

GERD: The current recommended adult oral dosage is 150 mg twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with ZANTAC, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: ZANTAC[®] 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

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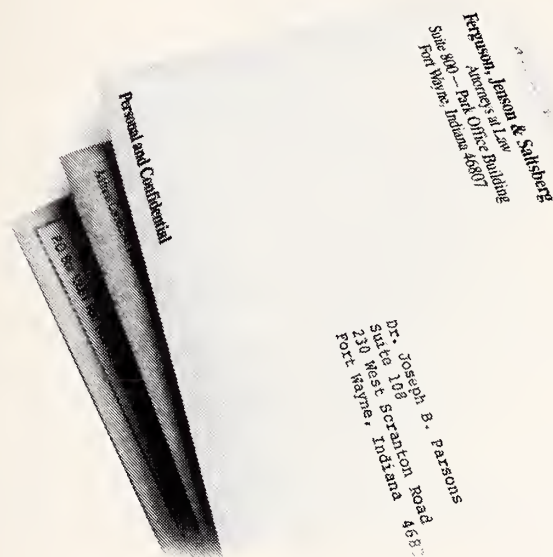
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Claim Settlement

(Continued from page 201)

interest of overriding significance. It repeated its earlier statement that mandatory malpractice insurance bears a rational relationship to the health and welfare of the citizens of the state by not only providing protection to patients who may be injured as a result of medical malpractice but by assuring that there continues to exist in the state an adequate supply of health care providers. The court then examined the claims that the provisions of the act allowing a settlement without the approval of the health care provider deprived him of a property right or a due process right. The court concluded that the provisions of the Act would be upheld as they provide an overriding state interest in maintaining adequate health care providers in the state as well as providing sufficient amounts to cover the economic costs of the claimant's injuries caused by medical malpractice.



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Myocardial Rupture

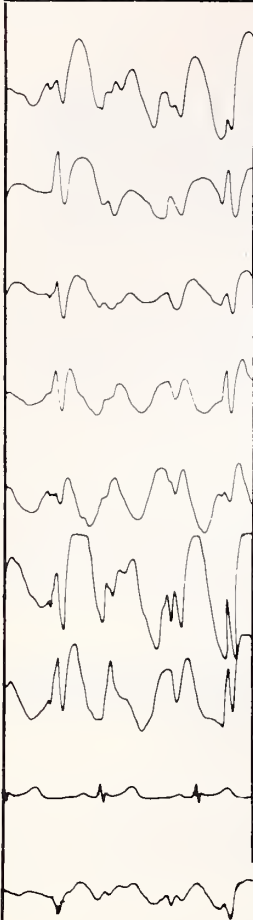
(Continued from page 195)

minute and regular. No thrills, murmurs, rubs, or extra sounds were present and her lungs were clear. Chest x-ray on the day prior to dismissal revealed satisfactory postoperative chest without cardiac enlargement. An echocardiogram done on June 5, 1986, had shown some left ventricular asynergy but fairly good overall left ventricular asynergy but fairly good overall left ventricular function.

Discussion

Rupture of the infarcted ventricle remains a dreaded complication of acute myocardial infarction. External rupture into the pericardial sac accounts for 10-15% or more of deaths due to myocardial infarction.³ Treatment is not possible for most patients because death occurs within a few minutes. An aggressive approach, including a high index of suspicion for the entity, may improve the patient's survival rate.

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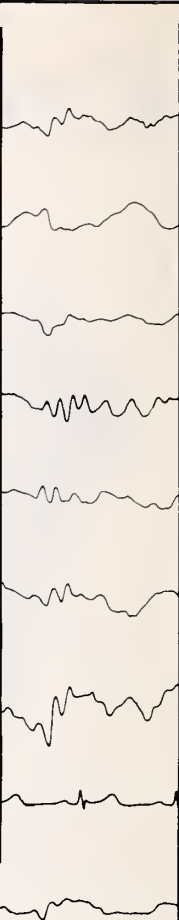
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septal insertions. Patients prone to rupture are hypertensives, women, the elderly, and patients ambulated early after infarction.⁴

Diagnosis is best achieved through maintaining a high index of suspicion. Electrocardiography is not diagnostic. Heart size is usually normal on roentgenography. Echocardiography as well as pericardiocentesis could be misleading as the blood in the pericardial sac is clotted.

Patients hospitalized for acute myocardial infarction who develop early signs of pericarditis and pump failure or cardiac tamponade should be evaluated early to assess the possibility of myocardial rupture, septal rupture, and acute mitral regurgitation. Hemodynamic monitoring with Swan-Ganz catheterization and stabilization with volume manipulation, vasopressors, or vasodilators should be initiated. Intra-aortic balloon counterpulsation is the next step to support the circulation and assist in finding a remediable cause for the left ventricular

dysfunction. Cardiac catheterization, if the patient's condition is sufficiently stable, may be helpful to delineate the status of the coronary arterial tree. To improve the survival for these patients, surgical intervention in this setting of cardiogenic shock should proceed without delay.

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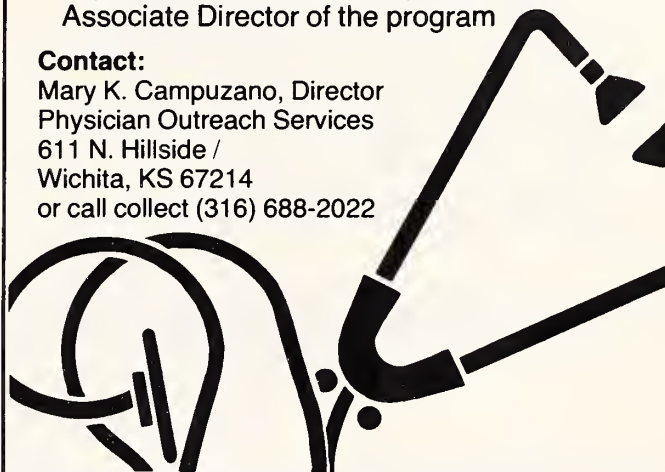
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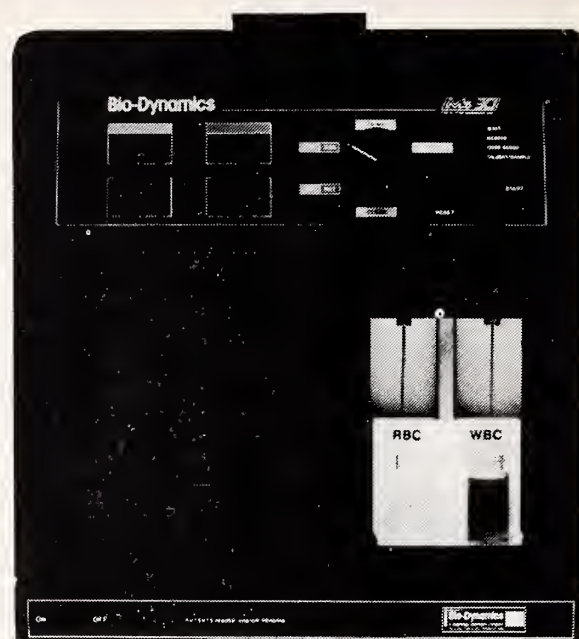
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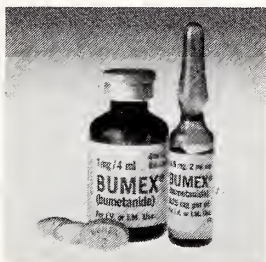
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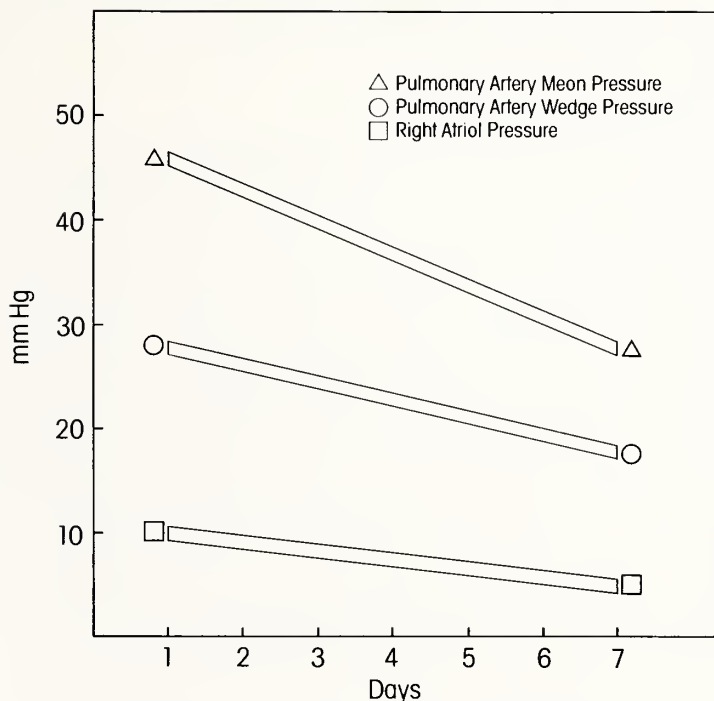
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Ten patients with CHF showed marked hemodynamic improvement after seven days of BUMEX® (bumetanide/Roche) (mean values $\pm$ SE). Adopted from Olesen, *et al.*¹

References: 1. Olesen KH, *et al.* *Postgrad Med J* 51(Suppl 6):54-63, 1975. 2. Handler B, Dhingra RC, Rasen KM. *J Clin Pharmacol* 21:706-711, Nov-Dec 1981. 3. Brater DC, *et al.* *Clin Pharmacol Ther* 34:207-213, Aug 1983. 4. Brater DC, Fox WR, Chennavasani P. *J Clin Pharmacol* 21:599-603, Nov-Dec 1981. 5. Davies DL, *et al.* *Clin Pharmacol Ther* 15:141-155, Feb 1974.

BUMEX®
bumetanide/Roche
0.5-mg, 1-mg and 2-mg scored tablets,
2-ml ampuls, 2-ml, 4-ml and
10-ml vials (0.25 mg/ml)

BUMEX® (bumetanide/Roche)
Before prescribing, please consult complete product information, a summary of which follows:

WARNING: Bumex (bumetanide/Roche) is a potent diuretic which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required, and dose and dosage schedule have to be adjusted to the individual patient's needs. (See under DOSAGE AND ADMINISTRATION in complete product information.)

INDICATIONS AND USAGE: Edema associated with congestive heart failure, hepatic and renal disease, including the nephrotic syndrome. Almost equal diuretic response occurs after oral and parenteral administration at Bumex. If impaired gastrointestinal absorption is suspected or oral administration is not practical, Bumex should be given by the intramuscular or intravenous route. Successful treatment with Bumex following instances of allergic reactions to furosemide suggests a lack of cross-sensitivity.

CONTRAINDICATIONS: Anuria. Hypersensitivity and in patients in hepatic coma or in states of severe electrolyte depletion. Although Bumex can be used to induce diuresis in renal insufficiency, any marked increase in blood urea nitrogen or creatinine, or the development of oliguria during therapy at patients with progressive renal disease, is an indication for discontinuation of treatment.

WARNINGS: Dose should be adjusted to patient's needs. Excessive doses or too frequent administration can lead to profound water loss, electrolyte depletion, dehydration, reduction in blood volume and circulatory collapse with the possibility of vascular thrombosis and embolism, particularly in elderly patients.

Prevention of hypokalemia requires particular attention in patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis and ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, certain diarrheal states, or other states where hypokalemia is thought to represent particular added risks to the patients. In patients with hepatic cirrhosis and ascites, sudden alterations of electrolyte balance may precipitate hepatic encephalopathy and coma. Treatment in such patients is best initiated in the hospital with small doses and careful monitoring of the patient's clinical status and electrolyte balance. Supplemental potassium and/or spironolactone may prevent hypokalemia and metabolic alkalosis in these patients.

In cats, dogs and guinea pigs, Bumex has been shown to produce ototoxicity. Since Bumex is about 40 to 60 times as potent as furosemide, it is anticipated that blood levels necessary to produce ototoxicity will rarely be achieved. The potential for ototoxicity increases with intravenous therapy, especially of high doses.

Patients allergic to sulfonamides may show hypersensitivity to Bumex.

PRECAUTIONS: Measure serum potassium periodically and add potassium supplements or potassium-sparing diuretics, if necessary. Periodic determinations of other electrolytes are advised in patients treated with high doses or for prolonged periods, particularly in those on low salt diets. Hyperuricemia may occur. Reversible elevations of the BUN and creatinine may occur, especially with dehydration and in patients with renal insufficiency. Bumex may increase urinary calcium excretion.

Possibility of effect on glucose metabolism exists. Periodic determinations of blood sugar should be done, particularly in patients with diabetes or suspected latent diabetes.

Patients should be observed regularly for possible occurrence of blood dyscrasias, liver damage or idiosyncratic reactions.

Especially in presence of impaired renal function, use of parenterally administered Bumex should be avoided in patients to whom aminoglycoside antibiotics are also being given, except in life-threatening conditions.

Drugs with nephrotoxic potential and bumetanide should not be administered simultaneously. Since lithium reduces renal clearance and adds a high risk of lithium toxicity, it should not be given with diuretics.

Probenecid should not be administered concurrently with Bumex.

Concurrent therapy with indomethacin not recommended.

Bumex may potentiate the effects of antihypertensive drugs, necessitating reduction in dosage.

Interaction studies in humans have shown no effect on digoxin blood levels.

Interaction studies in humans have shown Bumex to have no effect on warfarin metabolism or on plasma prothrombin activity.

Pregnancy: Bumex should be given to a pregnant woman only if the potential benefit justifies the potential risk to the fetus.

Bumetanide may be excreted in breast milk.

Pediatric Use: Safety and effectiveness below age 18 not established.

ADVERSE REACTIONS: Muscle cramps, dizziness, hypotension, headache and nausea, and encephalopathy (in patients with preexisting liver disease).

Less frequent clinical adverse reactions are weakness, impaired hearing, rash, pruritus, hives, electrocardiogram changes, abdominal pain, arthritic pain, musculoskeletal pain and vomiting. Other clinical adverse reactions are vertigo, chest pain, ear discomfort, fatigue, dehydration, sweating, hyperventilation, dry mouth, upset stomach, renal failure, asterixis, itching, nipple tenderness, diarrhea, premature ejaculation and difficulty maintaining an erection.

Laboratory abnormalities reported are hyperuricemia, azotemia, hyperglycemia, increased serum creatinine, hypochloremia, hypokalemia, hyponatremia, and variations in CO₂ content, bicarbonate, phosphorus and calcium. Although manifestations of the pharmacologic action of Bumex, these conditions may become more pronounced by intensive therapy. Diuresis induced by Bumex may also rarely be accompanied by changes in LDH, total serum bilirubin, serum proteins, SGOT, SGPT, alkaline phosphatase, cholesterol, creatinine clearance, deviations in hemoglobin, prothrombin time, hematocrit, platelet counts and differential counts. Increases in urinary glucose and urinary protein have also been seen.

DOSAGE AND ADMINISTRATION:

Oral Administration: The usual total daily dosage is 0.5 to 2.0 mg and in most patients is given as a single dose.

Parenteral Administration: Administer to patients (IV or IM) with GI absorption problem or who cannot take oral. The usual initial dose is 0.5 to 1 mg given over 1 to 2 minutes. If insufficient response, a second or third dose may be given at 2 to 3 hour intervals up to a maximum of 10 mg a day.

HOW SUPPLIED: Tablets, 0.5 mg (light green), 1 mg (yellow) and 2 mg (peach), bottles of 100 and 500; Prescription Paks of 30; Tel-E-Dose® cartons of 100. Imprint on tablets: 0.5 mg—ROCHE BUMEX 0.5; 1 mg—ROCHE BUMEX 1; 2 mg—ROCHE BUMEX 2.

Ampuls, 2 ml, 0.25 mg/ml, boxes of ten.

Vials, 2 ml, 4 ml and 10 ml, 0.25 mg/ml, boxes of ten.



ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

OVERLOAD

Reduce fluid volume and improve hemodynamics in CHF

Edema due to congestive heart failure often demands highly effective diuresis to reduce the fluid load on the failing heart. Bumex® (bumetanide/Roche) is the next generation in loop diuretic therapy for three powerful reasons. It moves out an unsurpassed volume of fluid and sodium, resulting in significant reductions in edema and right atrial and pulmonary artery wedge pressures.^{1,2} It's almost completely absorbed through the GI tract, so it's easy to

titrate.³ And Bumex completes high-volume diuresis fast—within four hours at usual doses.^{4,5} Your patients spend less time in diuresis, more time in normal activities.

Bumex has a good safety profile; however, as with all loop diuretics, Bumex, if given in excessive amounts, can lead to profound diuresis with water and electrolyte depletion, including hypokalemia. Serum electrolytes should be monitored periodically, especially in patients on low salt diets or those treated for prolonged periods or on high doses.

Bumex® 
bumetanide/Roche

0.5-mg, 1-mg and 2-mg scored tablets, 2-ml ampuls (0.25 mg/ml)
and 2-ml, 4-ml and 10-ml vials (0.25 mg/ml)

**First line
loop diuretic therapy**



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KMS Official Proceedings	209
About the Cover	210
History of Orthopedic Surgery	223
Neurocysticercosis	227
Resolutions	236
KMS Newsletter	228a

THE JOURNAL OF THE KANSAS MEDICAL SOCIETY



KANSAS MEDICINE

• The Journal Of The Kansas Medical Society •

Volume 88, Number 7, July 1987

Contents

Special Feature

- A History of Orthopedic Surgery at UKSM-KC — W. David Francisco, M.D., Kansas City, Kansas 223

Clinical Vignettes

- Neurocysticercosis — Henry R. Kuhns, Jr., M.D.; Jon A. Morgan, M.D.; Rubina Khan, M.D.; Hewitt C. Goodpasture, M.D., and Jerry D. Peterie, M.D., Wichita 227

Miscellaneous

- Annual Meeting Sponsors 234
Classified Advertisements 246
Council District Reports 216
Cover Story 210
Editorial Comment: *Owed to the Virus* 231
Impaired Physician Program Directory 247
Information for Authors 246
KFMC Update 233
KMS House of Delegates Official Proceedings 209
KMS Newsletter 228a
Medicina et Lex: *New Law Allows Exempt License* — Wayne T. Stratton, J.D., Topeka 232
Physician Directory 222
President's Message 230
Resolutions 236
Vox Dox 220

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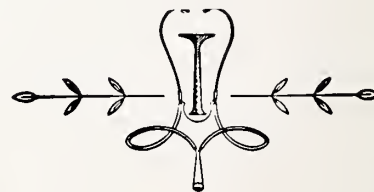
Information for authors

Manuscripts must be typewritten, double spaced, leaving wide margins. Authors are urged to carefully check manuscripts and galley proof for errors that could result in inaccurate information.

KANSAS MEDICINE will print a maximum of ten references; if more than ten are listed, the author(s) may designate the ten most significant to be printed and readers will be referred to the author(s) for the complete list.

Illustrative material must be identified by referral number and be accompanied by a short legend. Photos should be black and white glossy prints. Tables should be self-explanatory and should supplement, not duplicate, the text.

KANSAS MEDICINE will assume the cost of B/W engravings, cuts, and tables for two units. A unit is defined as ¼ page. The author(s) will be billed for additional units at cost.



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Official Proceedings

1987 Annual Meeting of the House of Delegates

Transactions of the 128th Annual Session of the Kansas Medical Society are published in this issue of KANSAS MEDICINE.

The resolutions are printed in numerical order following the minutes of the Second House of Delegates session. Those resolutions that were not adopted but were referred for further study or information are so indicated. The resolutions that failed to pass are retained in the official minutes at the executive office, but are not reported here.

FIRST SESSION

The first session of the House of Delegates of the Kansas Medical Society convened on Friday, May 1, 1987, beginning at 8:30 A.M. at the Holiday Inn Holidome, Manhattan. G. Rex Stone, M.D., Speaker, called the meeting to order. He then introduced Eugene Klingler, M.D., Manhattan Mayor, and Alex Scott, M.D., immediate past Mayor of Junction City, who welcomed the delegates.

Dr. Stone announced the presence of a quorum, explained the composition of the House, outlined the rules for conducting business, and stated that the House would follow the *Sturgis Standard Code of Parliamentary Procedure*.

The minutes of the 1986 meeting were approved. Tellers appointed for the primary election were Newton C. Smith, M.D., Arkansas City, Chairman; Frank H. Griffith, M.D., Salina; and John H. Rempel, M.D., Wichita.

The Speaker ordered distribution of the primary ballots. There being no nominations from the floor, members voted for the following slate:

PRESIDENT ELECT: Terry L. Poling, M.D., Wichita

FIRST VICE PRESIDENT: Alex Scott, M.D., Junction City

SECOND VICE PRESIDENT: Francis R. Applegate, Jr., M.D., Hays; Arthur D. Snow, Jr., M.D., Shawnee Mission; and Roger D. Warren, M.D., Hanover

CONSTITUTIONAL SECRETARY: Katherine Pennington, M.D., Wichita

TREASURER: Donald R. Brada, M.D., Hutchinson; and Larry Rotert, M.D., Topeka

AMA DELEGATE 1987-88: Lew W. Purinton, M.D., Wichita

AMA DELEGATE 1988-89: Jimmie A. Gleason, M.D., Topeka

AMA DELEGATE 1988-89: Linda D. Warren, M.D., Hanover

AMA DELEGATE 1987-88: Warren E. Meyer, M.D., Wichita

AMA ALTERNATE DELEGATE 1988-89: F. Calvin Bigler, M.D., Garden City

AMA ALTERNATE DELEGATE 1987-88: Stephen F. Miller, M.D., Parsons

AMA ALTERNATE DELEGATE 1987-88: Stuart C. Averill, M.D., Topeka; and Jay S. Schukman, M.D., Great Bend

AMA ALTERNATE DELEGATE 1987-88: John P. Brockhouse, M.D., Emporia; and Wayne O. Wallace, Jr., M.D., Atchison

The slate for House of Delegates officers was: Speaker: Larry R. Anderson, M.D., Wellington; and Ivan E. Rhodes, M.D., Wichita; Vice Speaker: Kenneth L. Derrington, M.D., Shawnee Mission.

KMS Auxiliary President Betty Glover addressed the House. (For the text of her report, see page 221.)

She then introduced Virginia Kutait, Fort Smith, Arkansas, AMA Auxiliary Treasurer, who delivered a brief address to the House.

The Speaker introduced Robert E. McAfee, M.D., Member of the AMA Board of Trustees. In his address, Dr. McAfee discussed the AMA's concern with a variety of issues that affect the delivery of health care — community hospitals' staffing, medical education, government-mandated services, business as the fourth party in health care delivery, HMOs, hospital accreditation, professional liability and tort reform, adequate health care for the increasing elderly population, and tobacco advertising. He concluded with a plea for a continuation of unified membership with AMA.

The Speaker announced the results of the primary election: Arthur D. Snow, Jr., M.D., Shawnee Mission, and Roger D. Warren, M.D., Hanover, will be the two candidates for Second Vice President on the final ballot.

Dr. Stone called for officers' and committee reports.

Cover

Photo by Philip H. Hostetter, M.D., Manhattan.
Vericolor film (Eastman), Leicaflex camera with 35
mm lens, 1/250 second exposure at F11. Scene is
about nine miles south of Manhattan on highway 177.

THE BARN AT QUAIL CREEK

Beyond my pane
higher ground supports
an aged barn —
unkempt and corrugated
by a thousand months of elements.

A dozen times a day
I watch it standing rough
against the smoothness
of the sky
sharing silence with its solitude.

It ghosts a hill and sometimes
it lets the wind
speak to me
of what an aged barn has known
and still believes in.

Reprinted with permission from *Barefoot Forever*
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Constitutional Secretary — Katherine Pennington, M.D.

Categories	Year-End 1985	Year-End 1986	Current Year thru 4/28/87
ACTIVE	2,276	2,058	1,911*
ACTIVE 1ST YEAR	24	17	41
PROBATIONARY	63	59	49
RESIDENT	89	145	175
STUDENT	593	600	586
ASSOCIATE	30	30	30
PERSONAL EXEMPT	37	37	29
RETIRED	306	356	373
MILITARY	7	4	4
EMERITUS	106	86	84
TOTALS	3,531	3,392	3,282

*Figure does not include 174 members whose dues are delinquent.

Treasurer — Roger D. Warren, M.D.

Dr. Warren asked the members to look over the
printed report and to direct any questions to himself
or to Gary Caruthers.

Necrology Committee — David E. Gray, M.D., Chairman

In John Irving's book, "Cider House Rules," the
old doctor, pondering the span of years of his prac-
tice, thinks to himself: "The hardest thing about
the passage of time is that those who once mattered
the most become increasingly wrapped up in pa-
rentheses."

Name & Address	Age	Date
Clyde W. Alexander, M.D., Kansas City	89	10-23-86
Frederick C. Baker, M.D., Topeka	52	4-13-87
Jay J. Carduff, M.D., Dallas	61	12-01-86
Rosellen E. Cohnberg, M.D., Cedar Vale	64	4-10-87
Francis T. Collins, M.D., Topeka	72	1-27-87
Arthur H. Dyck, M.D., McPherson	82	5-23-86
Grant E. Evans, M.D., Wichita	65	4-11-87
George R. Davis, M.D., Ellsworth	66	3-14-86
James B. Degner, M.D., Great Bend	54	4-08-86
Robert L. Ferguson, M.D., Shawnee Mission	39	1-15-87
Robert W. Friggeri, M.D., Pittsburg	62	8-12-86
E. Raymond Gelvin, M.D., Concordia	83	10-06-86
Charles I. Girod, M.D., El Dorado	75	6-22-86
Edward D. Greenwood, M.D., Topeka	85	9-16-86
Eugene C. Hwa, M.D., Newton	65	12-24-86
Addison C. Irby, M.D., Fort Scott	80	5-12-86
Robert C. Keys, Sr., M.D., Winchester	89	6-13-86
Harvey L. Lloyd, M.D., Kansas City	78	12-24-86
Earl A. Martin, M.D., Parsons	78	10-13-85
J. Tarlton Morrow, Jr., M.D., Topeka	63	11-14-86
Newman C. Nash, M.D., Scottsdale, Arizona	80	8-16-86
Ernest G. Neighbor, M.D., Kansas City	80	5-08-86

O. Vale Page, M.D., Plainville	67	3-23-87
George E. Paine, M.D., Hutchinson	92	2-13-87
John A. Segerson, M.D., Topeka	68	3-14-87
Albert W. Shiflet, M.D., Wheeling, Missouri	80	
Robert C. Tinker, M.D., Wichita	54	8-26-86
Thaddeus H. White, M.D., Manhattan	70	5-21-86
Horace M. Wiley, M.D., Garden City	74	10-07-86
Curtis V. Wolf, M.D., Lyons	49	10-13-86

Editorial Board —

David E. Gray, M.D., Chairman

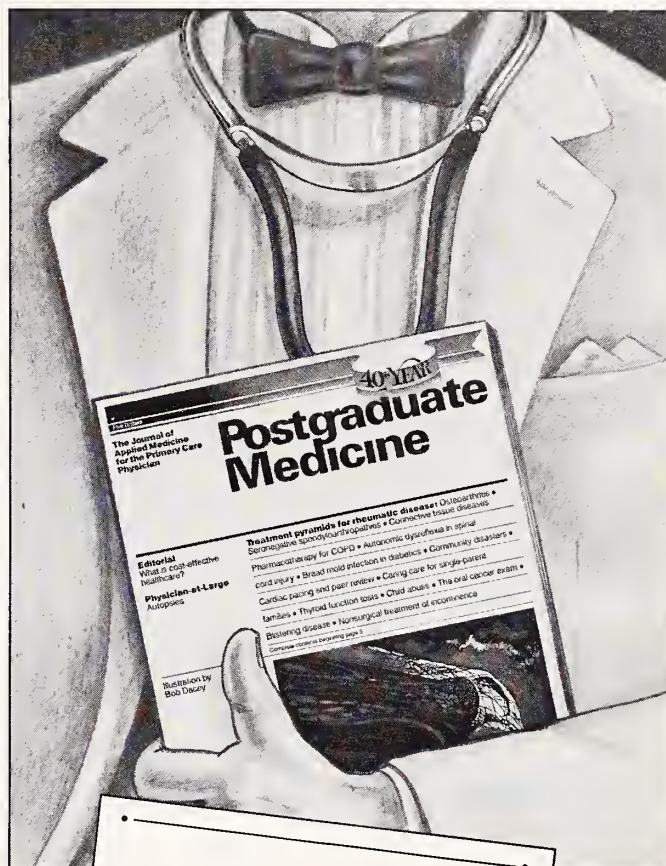
The need to produce a report for this body always reminds me that the routine daily activities of KANSAS MEDICINE give the impression of little change, but when viewed in the annual perspective there may be more than I thought in the process.

To address the persistent matter of finances, there is, however, little of actual difference. The Council and House of Delegates warrant our continuing thanks for the fact of our existence. We have gained a little and lost a little in revenues. Advertising remains a problem as it does for all periodicals. What we have gained in actual advertising has been offset by a decrease in the use of color which reduces income. By another measure, we are still in the midrange compared with others of our type so our attitude of affluence remains primarily one of spirit.

From time to time, we have introduced new items including "A Personal View" as well as occasional feature articles. In passing, I can say that the Editor is far too lazy to change the "Personal Views" in sense or substance beyond space requirements, punctuation, and so on. Let me take this opportunity not only to call your attention to these items but encourage your submitting your own offerings, and as usual, this goes for scientific articles as well. I would mention also that Wayne Stratton, legal counsel for the Kansas Medical Society, has asked for suggestions of topics which should be covered in his page. I feel his range has been excellent but he is concerned that Kansas physicians may have specific problems that could well be presented.

The covers over the past year have utilized historical maps relating to Kansas' early years. This series will terminate shortly not because the history is by any means exhausted but because the maps of more recent vintage begin to approach the modern type of road map. Knowing that many physicians are above average photographers, we will be using some of their contributions over the next year or so, depending upon future response. We are encouraged by having received some excellent items

FAMOUS PHYSICIANS ARE SHOWING UP FOR OUR 40th YEAR CELEBRATION.



Paul P. Griffin, M.D.
Robert G. Petersdorf, M.D.
Eric A. Ravitz, D.O.
J. Jerry Rodos, D.O.
Professor H.E. de Wardener, C.B.E.

Read Every Issue From Cover to Cover:

July

Symposium: Skeletal Problems

Special Article: Orthopedics 1947-1987 Paul P. Griffin, M.D.

August

Symposium: Infectious Diseases

Special Article: Infectious Diseases 1947-1987 Robert G. Petersdorf, M.D.

September 1

Symposium: Focus on Osteopathic Medicine Eric A. Ravitz, D.O.

Coordinator

Special Article: Osteopathic Medicine 1947-1987 J. Jerry Rodos, D.O.

September 15

Symposium: Renal Disease

Special Article: Renal Disease 1947-1987 Professor H.E. de Wardener, C.B.E.

40th YEAR
**Postgraduate
Medicine**

Every Issue is a Celebration of Clinical Information

Intraocular Lens Warning

The American Academy of Ophthalmology has called attention to the occurrence of vision problems in recipients of certain anterior chamber intraocular lenses. Although the majority of patients have experienced no complications, the risks to those affected warrant the advice to physicians generally who may receive questions about the procedure or the lenses, as well as ophthalmologists involved in the use of such lenses (who have undoubtedly been aware of the problems previously).

The following lenses as well as others have been reported as being involved:

Azar 91Z IOLab (voluntarily withdrawn from the market)

Lieske Surgidev Corporation

Stableflex Optical Radiation

and hope that you will continue to put us in the difficult spot of having to choose among them. Kansas sites of both historical and scenic interest are hoped for but the emphasis is as much on the photographer as the photograph, and out-of-state scenes are welcome as well.

The composition of the Editorial Board, after some years of little change, will be taking on some new faces. In the past year, the retirement of Dick Greer after many years of faithful and valued service and the untimely death of Jack Segerson have left vacancies difficult to fill. In addition, Lieutenant Governor Jack Walker, who for many years has represented the UKSM-KC is no longer officially connected with it (one of the few things he is not connected with), and we are recommending that Dr. James Price be appointed in his place. This does not mean that we are letting go of Jack — he will continue as a regular member for which we are glad. He has more responsibilities than anyone should be asked to carry, but we can be thankful that someone who wears so many hats knows where his head is.

We are also nominating Ralph Reed of Lawrence, and Harry Kroll and Jim Ransom of Topeka, to fill vacancies. It should be noted that over the past year,

the increasing technical complexity of some medical articles has been unrepresented among the sitting members of the Board in making valid decisions regarding publication. We have, therefore, occasionally sought the guidance of those conversant with those areas, and I am grateful to them.

I would be remiss to fail to give particular attention to Jack Segerson's service. His tenure on the Board began in 1957, and our loss is the greater because of this long service and his astute and sometimes pithy perceptions of manuscript value and the affectionate respect and friendship we all felt for him. We owe him much.

It remains for me to express my thanks to those who really do my job. Jerry Slaughter's role goes well beyond keeping an eagle eye on our business matters — although he does that well. His judgments and directions help keep us in touch with the real world. It is difficult to express my appreciation for the service and support Val Braun and Eleanor Bell give to me and to KANSAS MEDICINE without my becoming maudlin. If the financial situation becomes untenable, Jerry will do well to get rid of the Editor and keep the staff.

Our best efforts at economy never seem to avoid having a few extra copies of the journal lying around so we have decided to use them by binding them into a hardback version and presenting it to one of our faithful contributors, Frank Bichlmeier. Our thanks and best wishes for the coming year accompany it, Frank.

Drs. Gray and Bichlmeier exchanged bound volumes of KANSAS MEDICINE.

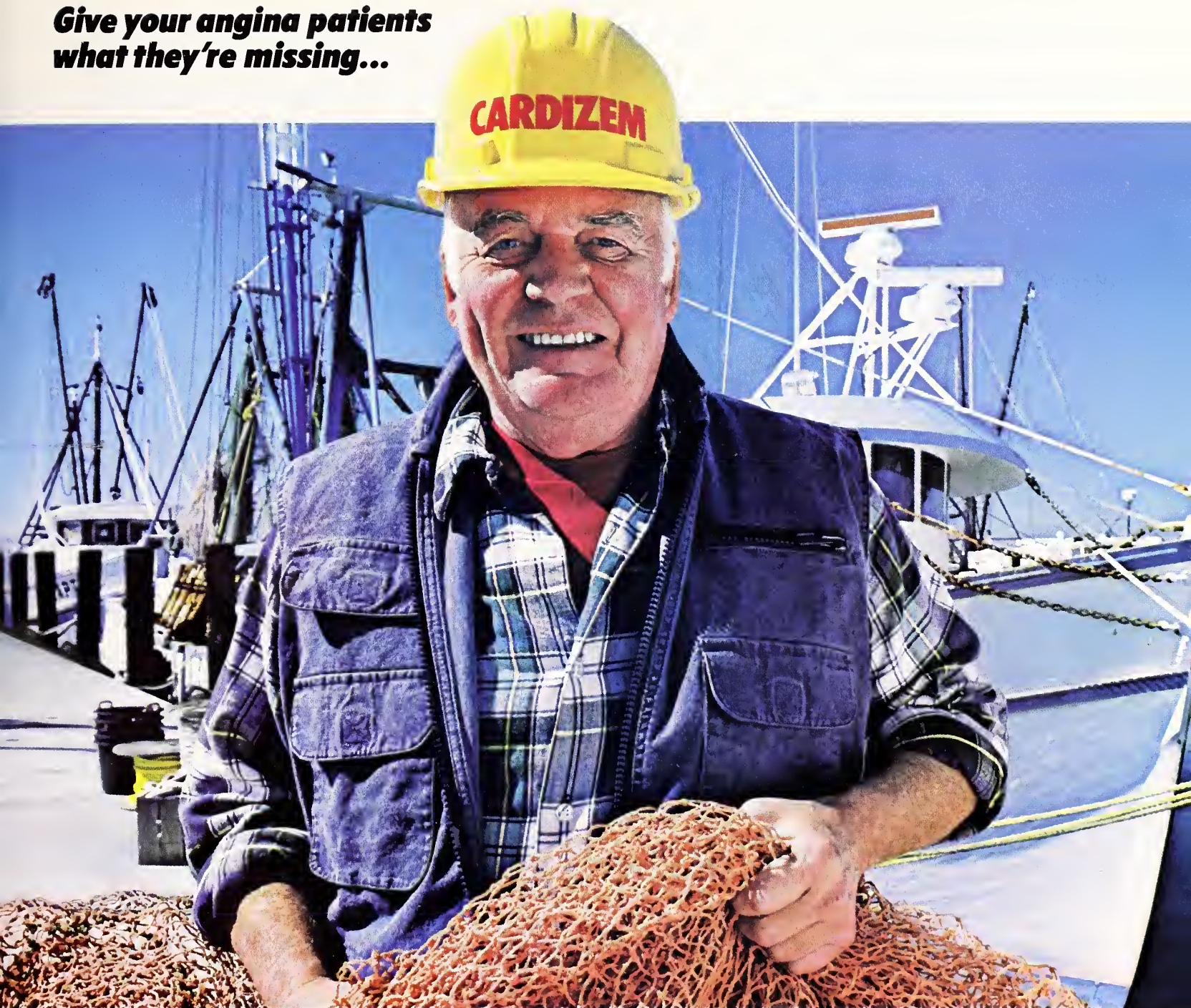
Professional Liability Committee — Jimmie A. Gleason, M.D., Chairman

Dr. Gleason discussed the constitutional challenge to the collateral source rule, the need to build public awareness with regard to the impact of malpractice insurance on health care costs, and the possibility that the tort reform bill, passed by the 1986 Legislature, could be held unconstitutional by the Kansas Supreme Court.

KaMPAC Committee — Roger D. Warren, M.D., Chairman

Dr. Warren noted that during its first year, KaMPAC had 200 members; during the year just completed — its seventh — there were 1,000 members. He announced the new KaMPAC offices as

**Give your angina patients
what they're missing...**



CARDIZEM® FEW SIDE EFFECTS

diltiazem HCl/Marion

- **Antianginal action includes dilatation of coronary arteries, a decrease in vascular resistance/afterload, and a reduction in heart rate**
- **Proven efficacy when used alone in angina¹**
- **Compatible with other antianginals^{2,3*}**
- **A safe choice for angina patients with coexisting hypertension, asthma, COPD, or PVD^{4,5}**

90 mg
NEW 120 mg
GREATER DOSAGE FLEXIBILITY

***See Warnings and Precautions.**

Please see brief summary of prescribing information on the next page.



CARDIZEM[®] FEW SIDE EFFECTS diltiazem HCl/Marion IN ANTIANGINAL THERAPY

60 mg tid or qid

Brief Summary Professional Use Information

CARDIZEM[®]
(diltiazem HCl) 30 mg and 60 mg Tablets

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

- 1. Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
- 2. Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
- 3. Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
- 4. Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic

function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of

Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy, Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated

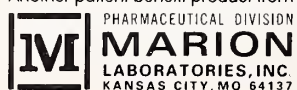
with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System:	Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic:	Petechiae, pruritus, photosensitivity, urticaria.
Other:	Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nicturia, osteoarthralgia, pain, paresthesia, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. See complete Professional Use Information before prescribing.

References: 1. Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers. Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. *Am Heart J* 1983; 106(6): 1341-1347. 2. Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. *Consultant* 1984; 24(Dec): 150-159. 3. Jahnson DL, Lesaway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris. A placebo-controlled, double-blind, randomized, crossover study. *Am J Cardiol* 1985; 55: 680-687. 4. Cahn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed) *Heart Disease: A Textbook of Cardiovascular Medicine*, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. 5. Schroeder JS: Calcium and beta blockers in ischemic heart disease. When to use which. *Mod Med* 1982; 50(Sept): 94-116.

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follows: Chairman: James A. Loeffler, M.D., Wichita; Vice Chairman: Carol Bichlmeier, Kansas City; Treasurer: Mary Boyd, Wichita; and Secretary: David B. Robinson, M.D., Topeka.

Dr. Bichlmeier presented a plaque to Dr. Warren in recognition of his service to the Kansas Medical Society as chairman of the KaMPAC Committee.

Impaired Physician Committee — Ivan E. Rhodes, M.D., Chairman

On direction of legislation enacted in 1986 — HB 2661 — the Kansas Medical Society entered into an agreement with the Board of Healing Arts whereby the Impaired Physician Committee (IPC) becomes a quasi-official extension of the Board in matters of physician impairment. Among the various functions thus placed on the IPC are: receiving and evaluating reports of impaired professionals; intervening in cases of verified impairment; referring providers to treatment programs; monitoring the treatment and rehabilitation of impaired providers, providing post-treatment support of rehabilitated providers; and performing other activities

as agreed by IPC and the Board. The reporting obligations under 2661 are satisfied when a report is made either to the IPC or to the Board.

The confidentiality aspect of IPC activities has been preserved under the agreement. No member of an IPC (state or local) can be required to testify in any civil, criminal or administrative action, other than a disciplinary proceeding by the Board, relating to any committee discussions or proceedings. The requirement of confidentiality of records and reports flows through such committee of professional associations up to and including the State Board of Healing Arts.

Quarterly reports of cases will be made on a statistical data basis. Immediate reporting by name, however, will be done in those cases when imminent danger to the public or physician him/herself is suspected. Also to be reported to the Board by name will be impaired professionals who refuse to cooperate with the committee, who refuse to submit to treatment, or whose treatment is unsuccessful.

The main thrust of the new law is to encourage the timely *identification and reporting* of health care professionals who are thought to be impaired by alcohol, drugs, physical or mental disabilities, including deterioration through the aging process. The

fact that the new law calls for a close working relationship between the Board and IPCs is an indication that the legislature believes that early identification and rehabilitation of impaired physicians is preferable to mere sanctions and punishments of affected professionals.

KMS will receive \$99,797 for the first fiscal year of operating the new program, beginning July 1, 1987. This represents partial funding for the program, but it will allow part-time employment of a medical director and a full-time RN coordinator. Val Braun will continue to direct the project. The committee will continue to pursue other sources of revenue, such as user fees, selling the program to other professional organizations, grants from the insurance and pharmaceutical industries, etc.

The new system will enable the committee to have exact statistical data, so that future reports before the House of Delegates by this committee will be more specific. This has been a very busy year. There are now either local IPCs or contact persons identified and in place in every local medical society in Kansas. The Councilors have generously consented to participate in the work of this committee to give it regional, geographically uniform representation. All of these efforts are gratefully acknowledged.

Since 1977, the Committee has had only two chairmen. I feel it is time for a change. While I intend to continue helping the program as a committee member, a new chairman will be selected. I wish to thank all those who have helped this effort along.

Dr. Bichlmeier recognized Dr. Rhodes' service to the Kansas Medical Society by presenting him with a plaque.

Kansas Foundation for Medical Care — Louis Culp, M.D., Chairman

KFMC continues to be very active in peer review activities in Kansas. As a physician-based organization composed of KMS physicians, KFMC strives to represent the interest of Kansas physicians and the KMS in our activities. This is a difficult task. In our role as a review organization, we are looked upon to be a cost-containment agent, quality-of-care advocate, policeman, educator, and patient advocate. These roles sometimes lead to concerns by various parties, especially in the eyes of those not directly involved in KFMC or its review process.

In this, my last address as president of KFMC,

I would like to share with you my views of the past and future. The sophistication of review activities has changed markedly in the past few years. Some of this change was brought about by changes in the payment systems. However, most was brought about by the demands of the marketplace. The purchasers of health care demand more and better ways of assuring quality medical care at the most efficient cost. The Health Care Finance Administration (HCFA), the largest purchaser of health care, is demanding more and more review with less resources than ever before. This strains everyone's ability to cope with the whole process and the questions about it, denials, quality issues, and in a very few instances (two cases to date), sanctions.

The Board of Directors of KFMC and staff struggle daily with how to improve the process within the available resources. Questions about increasing onsite hospital review and physician reviewer evaluations *all* have been partially or completely addressed. We continue to work with HCFA and Congress on physician participation in reconsideration hearings and adequate funding to conduct onsite review in the widest possible sense, and otherwise within the law, the regulations, and the confidentiality requirements.

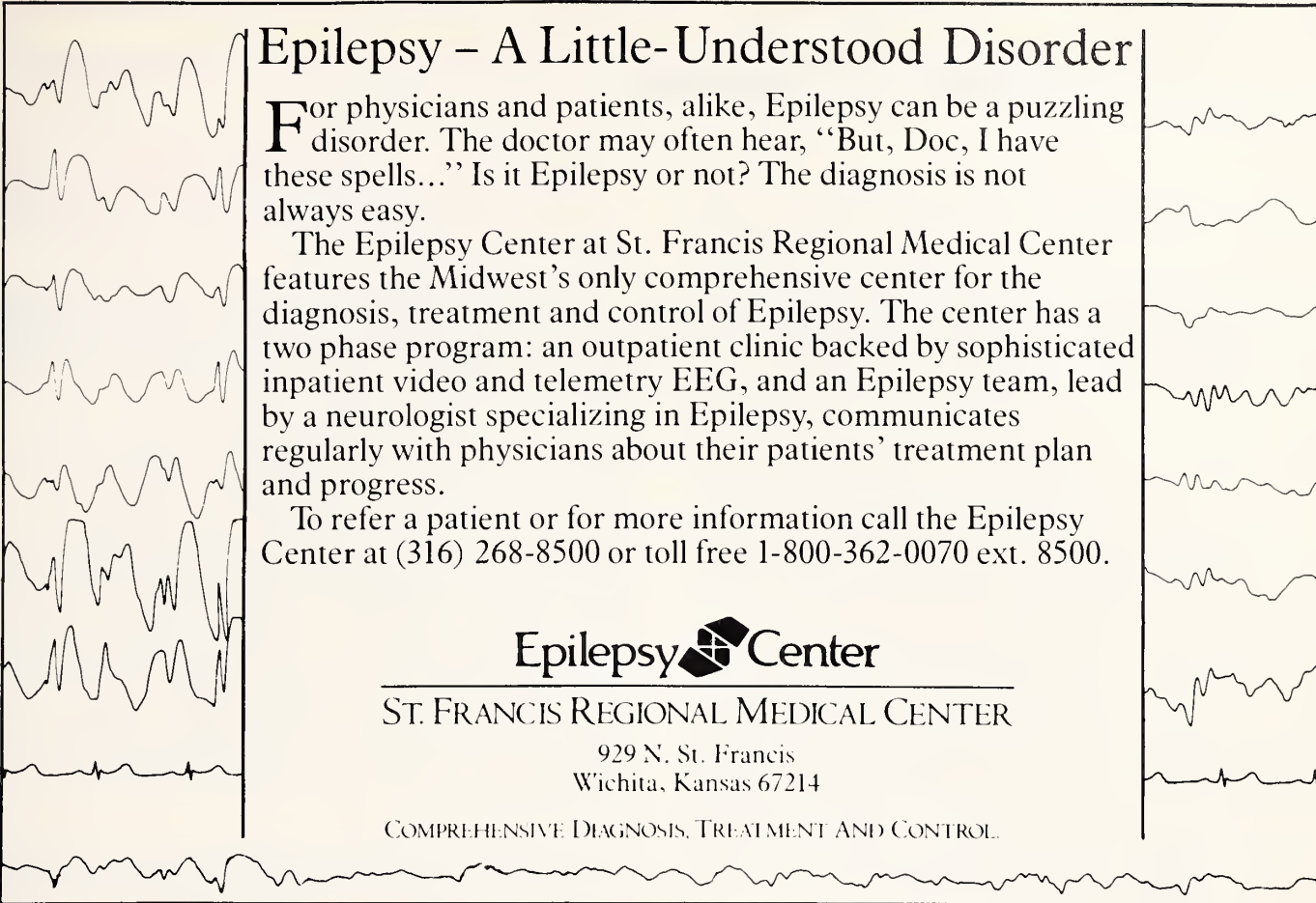
I want to thank the physicians who have worked so hard to carry out the difficult task of review, committee, and director functions. The hours and hours of work and sometimes undue and inappropriate criticism is something for which it is difficult to express appreciation. Bless you.

I also want to thank our staff. Their dedication, patience, and expertise are greatly appreciated and respected. They are terrific.

My final message to all Kansas physicians, as it has always been, is to hang in there if you have been involved, and get involved if you have not. To be critical of review activities and decisions with no understanding or experience of the process or problems associated with review is unjustified.

KFMC has in the past, and I am sure will continue, to address the demands of peer review while keeping in mind the needs of Kansas physicians, providers, and — most importantly — patients. There is no doubt or question that continued physician input and direction through participation in the review process are absolutely necessary to assure that quality and accessibility of health care are not compromised by economic decisions.

It has been my distinct honor and pleasure to serve as the President of the Kansas Foundation for Medical Care and to assist physicians of Kansas in their



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very important role of peer review.

Terry L. Poling, M.D., Chairman of the Hospital Medical Staff Section, gave a brief report.

Franklin G. Bichlmeier, M.D., KMS President, then addressed the House. He urged KMS members to pledge themselves to unity whatever the decision on unified membership. He stressed the importance of HB 2661, but noted that there are still many issues to be addressed and the physicians of Kansas must not allow themselves to be divided by external forces.

Jerry Slaughter, Executive Director, commended the leadership from the past year and expressed appreciation to the KMS staff. He reiterated Dr. Bichlmeier's call for unity among Kansas physicians. He explained that the recent change in the Kansas Supreme Court could result in an unfavorable ruling on the constitutionality of HB 2661. He explained that there has been a decrease in the number of physicians practicing in Kansas during the past two years and urged KMS members to maintain a high level of professionalism.

The Speaker announced that the following council districts need to caucus to elect new councilors: 1, 3, 5, 8, and 9. The results of the elections will

be announced at the second House of Delegates meeting.

Dr. Stone announced that Resolutions 1 through 30 will be referred to the reference committee. He then appointed the following physicians to serve on the reference committee:

Thomas L. Taylor, M.D., Shawnee Mission, Chairman; David A. Leitch, M.D., Garnett; J. Rand Neuenschwander, M.D., Hoxie; Joseph T. Phillip, M.D., Manhattan; and Jon F. Richards, M.D., Salina.

Dr. Stone recognized the State Meeting exhibitors. Following brief announcements of events still to come, the meeting adjourned.

SECOND SESSION

The Second Session of the House of Delegates was called to order by the Speaker, G. Rex Stone, M.D., on Sunday, May 3, 1987, at 8:30 A.M., at the Holiday Inn Holidome, Manhattan.

The Speaker announced the presence of a quorum and noted that the session would be conducted in accordance with *Sturgis Standard Code of Parliamentary Procedure*. He briefly reviewed some rules

(Continued on page 235)

Council District Reports

DISTRICT 1

Wyandotte County Medical Society was involved in much concern and planning during 1986 as results of unified membership became apparent. The loss of approximately 40 members was felt to be directly related to the unified program as established by the Kansas Medical Society House of Delegates. As a result of this drop in membership, our county society has joined the federal government in a deficit budget, and we were forced to rely on our reserves to maintain our programs and activities for the year.

A group of Jackson County (Missouri) physicians made a proposal to unite the various medical societies of the Greater Kansas City area. This was designed to give a larger group voice to the metropolitan physicians, but there seemed to be no possible mechanism to bridge the state line and still maintain our affiliation with the two state medical societies. However, this line of thinking has led to consideration of a merger of the Wyandotte and Johnson County Medical Societies. The two societies have shared program speakers on two occasions during the past year. Merger of the two societies would achieve administrative economy and provide a stronger voice for medicine in eastern Kansas, and the possibility remains under study.

In my opinion, the chief accomplishment of the Wyandotte County Society in recent years is the establishment and supervision of the KARE ambulance system for our community. The Emergency Medical Care Committee of Wyandotte County Medical Society has been the most active and devoted group of workers in the Society, and their work alone has justified the continued existence of our county society.

The matter of membership attrition produced by the unified membership provision remains the greatest concern to our society.

Richard A. Gruendel, M.D., *Councilor*

DISTRICT 5

In District 5, 1986-87 activities were primarily related to HB 2661 and its effect on the practice of medicine. The hospital committees have been active in preparing for implementation of our new role.

Activity in Manhattan and Junction City has centered around preparation for the Annual Meeting to be held in Manhattan.

Frank C. Lyons, M.D., *Councilor*

DISTRICT 6

Council District 6 is composed of the members of Shawnee County Medical Society. Our president this year has been David B. Robinson, M.D.

Throughout the year, Dr. Robinson has scheduled a variety of informative programs for our regular monthly meetings. The year began with our June annual meeting at which KMS President Franklin Bichlmeier, M.D. and our spouses were guests. In October, the Society sponsored a political forum at which Shawnee County legislative candidates were given an opportunity to discuss their views concerning upcoming legislative issues related to medicine. Other informative programs have included: "The Malpractice Reporting Act and How It Affects the Physician," by Wayne Stratton, J.D.; a symposium on "Topeka's Strong Mayor-Council Form of Government"; and a Blue Shield update by representatives of Blue Cross and Blue Shield of Kansas.

The Medical Society's interest in an increased involvement with the Topeka business community led to the formation of the Community Issues and Development Committee. This committee is composed of four society members and four members from the Greater Topeka Chamber of Commerce and serves as liaison between the two groups. A short report is made at each monthly meeting concerning current economic issues in Topeka.

The Society's radio program, "Doctors Call," entered its third year and presented 32 programs on different aspects of family medicine. The program is a call-in format, and guests are members of Shawnee County Medical Society.

Shawnee County Medical Society gained 20 new members during the year, but due to retirement and deaths, we still experienced a net loss in total membership of three.

We mourn the loss of five members this year, one a former KMS president:

Robert Keys, Sr., M.D.
Edward Greenwood, M.D.
J. Tarlton Morrow, M.D.
Francis T. Collins, M.D.
(KMS President, SCMS President)
John A. Segerson, M.D.
(SCMS President)

Robert D. Parman, M.D., *Councilor*
(Continued on page 218)

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after a major nationwide trial...



...we had
to find
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60,073 patients (90%) who started on INDERAL[®] LA stayed on INDERAL LA.^{1*}

Surprising? Not really.

Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.

A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients² revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol — which shows how well-tolerated once-daily INDERAL LA can be.

Sole therapy or concomitant therapy?

Fifty-nine percent of the time, INDERAL LA stood on its own.

The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were treated merely with the addition of a diuretic to INDERAL LA.

For the noncompliant patients in your practice, INDERAL LA may well be the answer.

Almost 20,000 of the patients in the nationwide compliance trial were identified as having been noncompliant with their previous antihypertensive therapy. Their physicians reported that 88% showed improved compliance when placed on once-daily INDERAL LA.

Control, comfort, and compliance

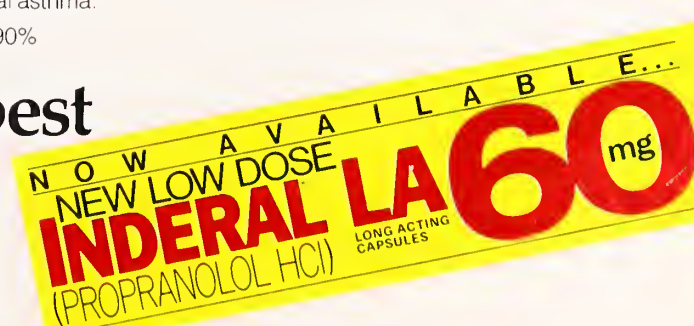
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INDERAL[®] LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

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keeps looking better**

Please see next page for brief summary of prescribing information.



The one you know best keeps looking better

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)

INDERAL® LA brand of propranolol hydrochloride (Long Acting Capsules)

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. **Hypertension:** INDERAL LA is indicated in the management of hypertension: it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. **CARDIAC FAILURE:** Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T₄ and reverse T₃, and decreasing T₃.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. **GENERAL.** Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should

be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenyltorn, phenobarbitone, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and lidocaine have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T₃ concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

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REFERENCES:

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DISTRICT 7

Council District 7 — the Flint Hills Medical Society — is comprised of physicians from Chase, Coffey, Lyon, Morris, Osage, and Wabaunsee counties. We meet nine times each year on the first Tuesday of the month in Emporia. Our 1986-87 officers have been Kendall M. Wright, M.D., President; Mark E. Pierson, M.D., Vice President; Barbara J. Howell, M.D., Secretary Treasurer; and W. Brock Kretsinger, D.O., Program Chairman.

Membership has increased slightly, although some other communities haven't seen fit to support organized medicine at the national level.

Several member physicians have retired from active practice during the past year: Thomas P. Butcher, M.D. (former KMS president); Kenneth R. Hunter, M.D.; Leo F. McKee, M.D.; and David P. Trimble, Sr., M.D. Jimmy E. Browning, M.D., relocated outside of the Council District. Marshall A. Havenhill II, M.D., discontinued obstetrical and gynecological practice, but continues as school physician at Emporia State University. Emporia has two new physicians: Renu Kumar, M.D., Pediatrics, and John C. Lloyd, M.D., Obstetrics and Gynecology.

Donald C. Coldsmith, M.D., was honored by being made a Fellow of the Great Plains Association. He is the author of a number of Western books, publications, and a syndicated column — "Horsin' Around."

James N. Glenn, M.D. serves on the Board of Directors of Newman Memorial County Hospital.

At our November meeting, we were honored to have KMS President Frank Bichlmeier, M.D., as our guest speaker. He brought us up to date on Kansas Medical Society activities.

During the year some of our members expressed concern about local hospital emergency room physicians' activities and about the development of "paramedical clinics" by the hospitals without local physician input.

One of our meetings was devoted to a discussion of the new SOBRA regulations and the calculation of MAAC fees as mandated by Medicare.

With most physicians, we continue to be concerned about rising medical liability insurance premiums and associated problems. We continue to have significant difficulty in dealing with the Medicare and Medicaid programs. We are still seeking solutions to improve local member interest and to overcome the organizational lethargy of young physicians.

John P. Brockhouse, M.D., *Councilor*

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DISTRICT 8

In several respects, this has not been a good year for District 8. Due to unified membership, we lost about one-half of the members in the Cowley County and Butler-Greenwood County Societies. It appears that they will not rejoin unless there is a change in this requirement.

Our district members met in Winfield in September with KMS President Frank Bichlmeier, M.D. He gave us an appraisal of measures to be considered by the Legislature and initiated a discussion about unified membership.

Several Cowley County physicians feel that the AMA has not been at all effective in opposing federal mandates. Some feel a strike is needed, and others recommend that the KFMC be changed to the KFNMC — Kansas Foundation for NO Medical Care. I agree with both.

We have had one hour of scientific medical education furnished for each of our meetings by UKSM-Wichita, and these have been informative and well-received, as well as providing CME credit.

We are presently at a low, and there is no direction to go but up.

Newton C. Smith, M.D., *Councilor*



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DISTRICT 9

Council District 9 met several times during the year and discussed the feasibility of participating in IPPs and PPOs.

In October, the District hosted a dinner for KMS President Frank Bichlmeier, M.D. and Mrs. Bichlmeier.

District members were also active in political matters prior to last fall's election.

David H. Clark, M.D., *Councilor*

DISTRICT 10

District 10 met November 25 at the Hutchinson Holidome. Thirty-seven physicians and spouses met with KMS President Frank Bichlmeier, M.D. and KMS Executive Director Jerry Slaughter for a presentation and discussion of KMS problems and concerns.

R. A. Siemens, M.D., *Councilor*

DISTRICT 11

The Wichita Preferred Provider Association is continuing to operate well and has increased its coverage to 20,000 lives. Companies include Beech Aircraft, Coleman, and Chamber of Commerce en-

dorsed insurance plans. The Medical Society of Sedgwick County sponsored insurance plan continues to function quite well.

At present, our unified membership is in excess of 95%, and we hope this will improve.

Our local society has established a broader participation of its members in the elective process for KMS delegates and it is expected that this will provide better representation for MSSC members.

The Emergency Medical Service Committee (EMS) is very active in cooperation with the Sedgwick County EMS program, advising of any changes in protocols to insure excellent and efficient service to our community.

The Medical Careers Loan Fund continues to have more applicants than funds, but has assisted four additional individuals during the past year.

The Legislative Committee continues to be quite active again at this, the most important time of the year.

Clifton C. Schopf, M.D., *Councilor*

DISTRICT 12

Tri-County Medical Society disbanded for lack of attendance. Barber County members chose to join the Ninnescah Society.

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Ninnescah Society meetings, held four times a year, include spouses or friends. The program is usually not of a medical orientation.

Northwest Kansas Area Health Education Center at Hays sponsors a continuing education program at Pratt the third Thursday of each month. All physicians are welcome.

We sincerely welcome the new physicians who have chosen to practice in this district. Janaki Varadhan, Vascular and General Surgeon, joined the Pratt Surgery Group in October.

L. Theil Bloom, M.D., *Councilor*

DISTRICT 14

The most significant change experienced by District 14 during the past year has been the loss of the administrator at Central Kansas Medical Center. Sister Philomena Hrencher had been administrator for 20 years at the time of her retirement. The Catholic Health Corporation, headquartered in Omaha, Nebraska, has been instrumental in the search for a new administrator and in assisting the hospital with strategic planning that will enable better adaptation to the changing environment experienced in health care today.

VOX DOX

To the Editor:

This is in response to the item on geriatricians in the May issue of the *Newsletter*.

No one can deny the "graying of America," and organized medicine has recognized the need for education in the field of geriatrics. However, organized medicine has also recognized the fallacy of continual segmentation of medical care and has wisely decided that there would be no sub-specialty of geriatrics. The American Board of Family Practice and the American Board of Internal Medicine have proposed and are developing two-year fellowships in this field. The physicians who complete these fellowships will not be sub-specialists, but will be recognized by a Certificate of Added Competency in geriatrics.

Our training program has been awarded a large grant to teach geriatrics to family practice residents, and we hope to develop a fellowship in that area to solve some of the needs mentioned in the *Newsletter* item.

E. J. Chaney, M.D.

Director, St. Joseph Family Practice
Residency Program

Associate Professor, Dept. of Family
& Community Medicine, UKSM-Wichita
1131 So. Clifton, Wichita KS 67218



The smaller community hospitals in District 14 have continued to respond to the changing environment in medicine by offering new services and expanding services in swing-bed facilities, extended care facilities, and drug and alcohol rehabilitation units.

The physician population in District 14 has remained relatively stable, although recruitment of new physicians remains a high priority for the entire district. HMOs, PPOs, and other associated organizations have continued to increase in scope and demand, and continued adaptation to these pressures is required.

Great concern has been expressed in District 14 regarding unified membership, as virtually all members want to see the AMA demonstrate a stronger national posture.

Overall, the district has responded well to the changing environment in medicine and to the eco-

conomic pressures brought to bear by the present problems of the oil industry and agriculture.

Donald L. Wikoff, M.D., *Councilor*

DISTRICT 16

Council District 16 covers the same area as the Northwest Kansas Medical Society — basically ten counties. The active membership of the Society continues at 31; three have left and three have come into the area.

The Northwest Kansas Medical Society meets two or three times each year immediately following the Circuit Courses. The Society always appreciates the annual visit of the KMS President, and the turnout for that meeting is usually good for the dinner and discussion. The visit last fall with KMS President Frank Bichlmeier, M.D., was of particular interest to me because Frank and I were classmates in medical school.

Asher W. Dahl, M.D., *Councilor*

DISTRICT 18

Our district has lost 37% of its membership because of unification. This has ruined any meaningful organization in Douglass County as many physicians have withdrawn to seek representation in a single specialty organization.

On the positive side, Ottawa and Franklin Counties will gain four new physicians. This should increase the availability of medical care and improve their hospital census.

All hospitals in our district are suffering because of low occupancy. Coupled with freezes in reimbursements and demands for increased salaries and increased technology in diagnostic and therapeutic areas, we fear the closure of small rural hospitals such as Garnett, and the resultant transfer of patients and their physicians to more urban areas. This will again result in a maldistribution of physicians — a situation which had improved during the past five years.

David A. Leitch, M.D., *Councilor*

Address by KMS Auxiliary President — Betty Glover (Richard)

I have appreciated being able to attend your Executive and Council meetings this past year. It has surely given me an insight into all that you dedicated physicians are doing to help *all* physicians in the state.

We are your Auxiliary and we are doing a good job to promote you in every way, and you have

shown us how much we are appreciated. The National Auxiliary has asked that all counties and states work for better relationships with their medical societies, and I can unconditionally say that our relationship is good. It has been suggested that local medical societies have Auxiliary representation on their boards, something you can consider.

This past year has been successful in many ways. Our fall conference on teenage pregnancy brought forth the full impact of this widespread social problem and we hope some of the schools in the state will incorporate the concepts of Coleen Kelly Mast's program on sex respect.

Legislatively, we worked hard to elect a governor, lieutenant governor, and other elected officials who would be favorable to medicine, and we succeeded. For our success in that regard, we were invited to the Governor's mansion for breakfast on our Legislative Day.

Every auxiliary has different projects and each is a definite plus in its own community. We work alone and in coalition with other groups to improve health care. But we, too, have our problems, and membership is the big one. We had just barely enough members to send four delegates, plus our president, to the national convention this year. Membership is a constant struggle for us, just as it is for you, and you can help us: If you have a spouse who is not a member, encourage him/her to join, or you join for your spouse. Recently I wrote to the physicians in McPherson asking for their help to increase our membership, and six of them responded with memberships for their spouses.

AMA-ERF is one of our biggest projects, and I am amazed each year at how much we are able to give to our medical schools. This year I have taken a quilt and pendant to each county that I have visited, as well as other places, and just recently learned that we have raised more than \$1,900 from that project. I have my Harvey County to thank for those beautiful items. You may still purchase tickets, and I hope you will give generously.

Phyllis Bigler and I have traveled far and wide over the state this past year — some 4,000 miles — and everywhere we went we were impressed with the lovely and hard-working spouses you have chosen.

I want to acknowledge all the assistance I received from your medical society staff — they have been more than helpful.

I am confident that if everyone works together we will be able to achieve a better tomorrow for medicine.

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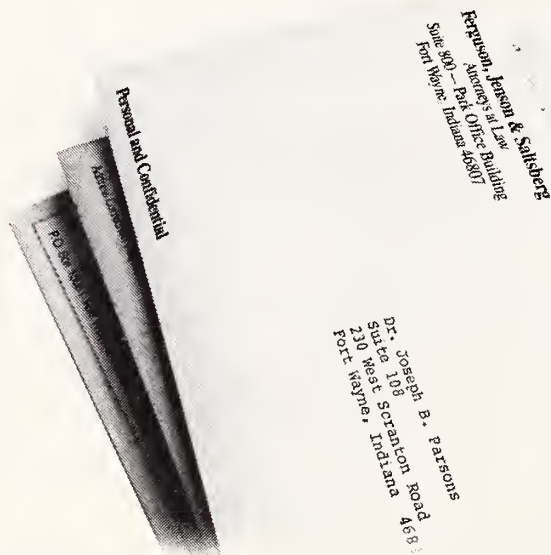
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SPECIAL FEATURE

A History of Orthopedic Surgery at UKSM-KC

W. DAVID FRANCISCO, M.D., *Kansas City, Kansas*

AT THE TURN of the century, the University of Kansas had a two year preclinical medical school program at Lawrence. The few graduates transferred to the University of Chicago or other schools to complete training for M.D. degrees. Through Dr. Simeon Bell's gift of land in Rosedale, now a part of Kansas City, Kansas, and the effort of Dr. Robert McEwen Schauffler, the first orthopedic surgeon in Kansas City, the two year clinical program was established. Dr. Schauffler was a trained general surgeon who, by travel and study in Europe and subsequent practice, became interested in orthopedic surgery and then restricted his practice to that specialty. He was secretary of the Kansas City Medical College, one of the three schools that united to form the Kansas University clinical program.

The roots of the University of Kansas School of Medicine (K.U) clinical program lay in three proprietary medical schools that joined in 1905 to form the Kansas City, Kansas, University School of Medicine clinical program, and their faculties provided the initial medical teaching staff. One well known Kansas surgeon, John Thomas Axtell, had commuted from Newton by train for several years to lecture in orthopedics at the College of Physicians and Surgeons in Kansas City, one of these three root institutions. Dr. Axtell had established the first nurses' training program in Kansas, used ivory bone pegs for fractures, and established the Axtell Clinic.

In the early years of the Kansas Medical School, orthopedic lectures were given by members of the Department of Surgery, whose orthopedic experience varied greatly. Clinic sessions were held at the school, at the "north side clinic," and at Mercy

Hospital. During this period, some senior students were selected as house officers.

Both the catalogue and the *Jayhawker* of 1905-06 list Drs. Charles Spaulding and Ernest van Quost as lecturers in orthopedic surgery. Their names disappear in the ensuing year. Dr. Spaulding was a graduate of Harvard and Bellview Medical Colleges, with post-graduate experience at Boston Children's Hospital and at the Society for the Lying-In Hospital in New York. He served in the U.S. Navy during the Spanish American War and was Professor of Obstetrics and Gynecology at the Kansas City Medical College during the school year 1904-05. His 1906 obituary in the *JAMA* lists the cause of his death as a fall down the elevator shaft of the old Rialto Building in Kansas City, Missouri.

The next year, orthopedic surgery lectures were given by Dr. Schauffler, who is listed on the Surgery Department Staff roster. In 1909, Dr. Schauffler relinquished his post at K.U. to Dr. C. B. Francisco, a 1907 graduate of K.U. Medical School who did residency work at the Hospital for the Ruptured and Crippled (now Hospital for Special Surgery) in New York in 1907-08. Dr. Francisco is listed in his faculty appointment as being a house officer for the 35-bed Eleanor Taylor Bell Memorial Hospital in 1906-07 and may have been the first K.U. house officer. He returned to Kansas City in 1909 as its first formally trained orthopedic surgeon. By this time, Dr. Schauffler had become Chief of Orthopedics at Children's Mercy Hospital where he continued to serve for many years until his death in 1955.

Another surgeon, Dr. Walter S. Sutton, had become an assistant professor of surgery at K.U. in 1909. He graduated in the Arts Program at K.U. and started research there, which he continued at Columbia University on a fellowship in zoology.

Address reprint requests to Dr. Francisco, Department of Surgery, Orthopedic Section, UKSM-KC, 39th & Rainbow Blvd., Kansas City, KS 66103.

He published a landmark paper entitled "The Chromosome in Heredity." He graduated from the College of Physicians and Surgeons at Columbia University and took an internship in New York before establishing his surgery practice in Kansas City, Missouri. The K.U. catalogues for 1909 to 1916 list him as a lecturer in orthopedic surgery. He served six months in France as a volunteer surgeon with the American Ambulance Company, and developed instruments and technology for x-ray localization of foreign bodies. He died in 1916 of a ruptured appendix.

Dr. Francisco was studying and touring orthopedic hospital centers in England when World War I broke out. He immediately returned to Kansas City, and in May 1917, joined the Goldthwait unit that sailed to Great Britain to work in British army hospitals before joining American units as they came to France. He was first assigned to Aberdeen, Scotland where the future Mrs. Francisco was working as an x-ray technician. Dr. Francisco was transferred to France in November and served with the First Division, then supervised the care of a large number of casualties at Huesse, France. He ended his service as acting head of the orthopedic section of the American Expeditionary Force after hostilities had ceased.

Dr. Frank Dickson, who had trained in orthopedic surgery at the University of Pennsylvania and then established his practice at St. Luke's Hospital, was appointed in 1917 to take Dr. Francisco's place, but was himself soon called to the colors. Dr. Schauffler filled in teaching orthopedic surgery until Dr. Francisco returned in 1919 — with a Scottish war bride — to practice.

During the first 20 years of its existence, medical school and hospital activities took place in two and then three small buildings on "goat hill" on the land given by Dr. Simeon Bell. These buildings were several blocks north of the current Medical Center, uphill from Southwest Boulevard, and a few blocks east of Rainbow Boulevard. The buildings were used for many years after the construction of the initial buildings at 39th and Rainbow. Chronic pulmonary patients were treated in one of these units — the Eleanor Taylor Hospital — for many years. Now there are no remnants of those buildings. The "north side clinic," mentioned in early catalogs, closed after a few years. Much teaching of medical students was done at old St. Margaret's Hospital, and this institute was affiliated with K.U. until 1945. Also, some teaching was done at Children's Mercy Hospital by Drs. Schauffler and Francisco.

The present administration building at 39th & Rainbow Boulevard and present campus were built on land secured in part by donations from the alumni of K.U. Medical College. Dr. C. B. Francisco was one of the leaders in this drive. The first building was completed in 1924. Because few other funds could be secured from the Kansas Legislature, the first building served for administration, library, operating room, private rooms, and wards. It also housed the emergency room and x-ray in the basement. Wooden temporary buildings just to the north and east of the old nurses' home housed the clinics and the Negro wards. These were not razed until well into the '30s, and it was not until about 1950 that the operating room was moved to the fifth floor of the corridor building.

The '20s and '30s were a period of slow growth for the institution. There were at first only two full time clinical men, Dr. Thomas Orr (surgery) and Dr. Ralph Major (medicine). But there were a large number of talented clinical professors in other fields. Dr. H. Roswell Wahl was the pathologist, and he succeeded Dr. Mervin T. Sudler as dean. He also was hospital administrator after Dean Sudler was fired from his position by the governor.

The addition of Dr. Galen Tice in x-ray and Dr. Ronald Rose in physical medicine in the '30s did a great deal to improve the orthopedic care given by the hospital and staff.

Dr. C. B. Francisco conducted crippled children's clinics throughout Kansas. He also had clinics and performed surgery at Children's Mercy Hospital and attended patients in a number of private hospitals throughout the Kansas City area. He demanded good work of the staff and was popularized in a ditty as the "bear that walks like a man." He lectured students and used a recitation that started with "Is it something or nothing? Is it inflammatory, neoplastic, congenital . . .," and on down the line. For many years he entertained the senior class with a class picnic at his home.

Dr. Francisco often used the Thomas wrench in treatment of clubfeet, the Bohler clamp in os calcis fractures, and considered the diagnosis of osteomyelitis as an indication for emergency incision and drainage.

In the 1920s, the house staff at K.U. was composed basically of interns. In 1924, according to Dr. Ralph Major, these were "real interns" or graduate M.D.s not the student house officers who had been present in earlier years.

In 1922, Dr. James Elliott was appointed an assistant in orthopedics. He had trained as a preceptor

with Dr. Frank Dickson at St. Luke's Hospital for two years.

In 1927, Dr. James B. Weaver became Dr. Francisco's associate. He had been an army corpsman in World War I, returned to K.U. to secure his B.S. and M.D. degrees, and then served a one-year internship in the Fifth Avenue Hospital in New York and a one-year internship at the Hospital for the Ruptured and Crippled. He took a two-year leave of absence (1929-1931) to fill the position of resident surgeon for the construction company building Bagnell Dam that created Lake of the Ozarks. Dr. Weaver replaced Dr. James Elliott who continued to teach and work at St. Margaret's Hospital.

It is not known exactly when Dr. Orr began the surgical residency program at K.U., but it must have been in the late '20s or early '30s. The program may originally have been two years, but it soon became three years. In the second year, residents did a six month rotation on the orthopedic and plastic surgery services. Thus, the K.U. trained general surgeons were well instructed in fractures. Dr. Major states there were two surgical residents in 1934, when there were eight interns. In the '30s, much building took place with the construction of the ward building, children's wing, Eaton Ward, and Hixon laboratory.

World War II made great demands on the institution. The 77th Evacuation Hospital was organized in 1940 and activated in May 1942. Most of its doctors and nurses were from K.U. Dr. Weaver was Chief of Surgery throughout the unit's work in Africa, Sicily, France, Belgium and Germany, and was awarded the Legion of Merit. He would not talk much of his experiences, but would deliver a tirade about the problems of the North African mud. The unit had periods of tremendous activity and intervening times of boredom. Another member of the unit was Dr. Paul Harrington, Chief of Orthopedics, who had graduated from K.U. Medical School after being a star basketball player in college here, and had taken a preceptorship with Dr. Dickson.

During World War II, Dr. Francisco developed a malignancy, and died in February 1944. The Francisco Lounge is named in his honor, and his memorial fund helped make the Student Union possible.

During the absence of Dr. Weaver and at the death of Dr. Francisco, Dr. James Elliott again came into the breach and taught orthopedics. He was a happy, pleasant individual, a perpetual cigar smoker, and one who liked to sit and talk. Dr. Frank Dickson

had been reappointed as a clinical professor in 1936 and may also have helped fill the vacancies.

When Dr. Weaver returned to K.U. in 1946, he organized the orthopedic surgery residency. The first resident was Dr. Ivan Cain, who was passing through Kansas City in 1946 and dropped by K.U. to see what residencies were open. He started work in October of that year. Other early residents were Dr. Stephen Fox and Dr. Charles Vilmer who became a part-time instructor until 1957.

There were three slots, one each year, available for orthopedic residents in the three-year program. The resident on call had to sleep in, but there were no formal conferences or curriculum. Several of the early residents spent only part of their time at K.U. Dr. Vilmer and Dr. W. David Francisco (the author), son of Dr. C. B. Francisco, served a year at Children's Mercy Hospital as part of the K.U. program. This affiliation was then assumed by the Dickson and Dively orthopedic residency program.

Dr. Weaver hired two part-time assistants in 1949 — Dr. Campbell McCullough, who was here only briefly, and Dr. Mike Donovan, who soon went to Houston to practice.

In 1950, Dr. Ed Haslam completed his final six months of residency at K.U. and was then hired as an associate. He worked at K.U. for two years, then moved to New Orleans where he became a Professor of Orthopedic Surgery at Tulane. He has since died.

After completing his residency and six months hospital work in the Navy in the Korean War, the author, at Dr. Weaver's suggestion, established a cerebral palsy clinic in late 1951. This clinic continues quite active today. It has always been a multispecialty clinic with a neurologist, speech pathologist, physical therapist, and occupational therapist often present and other specialists available at various times. Drs. James Laidlaw, John Pazell, and Stephen Bubb have also taken part of this program.

Dr. Weaver was half-time at K.U. and half-time in his office during his period as Chief of Orthopedics until his death in 1956. He would turn off his phone at night. His energy was drained by a chronic malignancy, but he remained active at work. His strongest interest was children's work. He also established a bone bank and started the Children's Rehabilitation Unit.

Dr. Lynn Litton was appointed to a full-time position on completion of his residency here in 1953. He was a pleasant, hard working orthopedist who was interested in sports medicine and scoliosis. He remained here until 1965 when he accepted a post as Professor and Chairman of Orthopedic Surgery

at the University of Missouri in Columbia.

Dr. Leonard F. Peltier was appointed Professor and Chairman of the Section of Orthopedic Surgery in January 1956, following the death of Dr. Weaver. Dr. Peltier trained at Minnesota University, passed his Boards in both general and orthopedic surgery, and was interested and trained in research. He also was deeply involved in children's orthopedics. He worked with plaster of Paris pellets as a substitute for bone grafts and championed the use of Rush rods, but his most important research lay in the field of fat embolism. His other clinical interests were in trauma and tumors. He established the James B. Weaver Endowment Fund, and the James B. Weaver Orthopedic Research Laboratory.

During Dr. Peltier's period, the residency program developed a rotation at old St. Margaret's Hospital. Later, in 1978, the program moved to Bethany when St. Margaret's merged with Providence Hospital and moved to the suburbs. Drs. Laidlaw, Pazell, and Bubbs were active as attendings, and the late Dr. Phil Nohe, as well as Drs. Richard Gruendel, Fred A. Rice, and Frederic Gilhousen's orthopaedic group were active at conferences and encouraged resident help in their surgery cases. The rotation was replaced by a research rotation in 1985.

Dr. Federico Adler was appointed to the volunteer staff in 1964, after completing his residency. He worked with Dr. Litton in scoliosis treatment and was the unofficial chief of the scoliosis clinic. He later worked closely with Dr. Marc Asher, who gradually took over the scoliosis work. Dr. Adler is still on the volunteer staff.

Dr. Frederick Reckling finished his orthopedic surgery training at K.U. in 1964. After military service in the Air Force, largely in Florida, he returned in July 1966 as a full-time associate with Dr. Peltier. He was appointed Chief of the Section of Orthopedic Surgery on Dr. Peltier's resignation in June 1971, and has maintained his leadership since that time. His chief clinical interests are trauma and joint replacements.

Shortly after Dr. Peltier's departure, Dr. Marc Asher was appointed as Dr. Reckling's associate in January 1972. He was a K.U. graduate who had trained at Massachusetts General Hospital and was briefly on the teaching staff at the University of Texas in San Antonio. Dr. Asher's primary interests are children's orthopedics and scoliosis, although he has continued, as have all other full-time staff, to carry his emergency room and trauma call. At first he did much general orthopedics, but has be-

come a national leader in scoliosis treatment and is very interested in spina bifida problems.

Six months after Dr. Asher's appointment, Dr. Rae Jacobs was appointed half-time director of the emergency room and half-time in orthopedics. He brought with him a background of a full general surgery residency and two years in research at the University of Buffalo before his orthopedic training at the Medical College of Georgia. He has been the leading research person on the orthopedic staff. He has been particularly interested in adult spine surgery and has developed his own "J" rods for internal fixation of the spine. He also has been the faculty person in charge of the Kansas City, Missouri V.A. orthopedic service since 1975. Two residents rotate to the V.A. from K.U. and two from Truman Medical Center. The K.U. residents spend two six-month rotations there. At first, Dr. John Barnard and other staff people from the Dickson and Dively program were active, but now K.U. provides the total orthopedic staffing at the V.A. hospital.

Dr. James Neff was recruited in July 1975. He was a K.U. graduate who completed his residency at the University of Michigan after a period as a Naval submarine medical officer. He had a fellowship with Dr. William Enneking in Florida, then was an assistant professor at the University of Florida for one year. He has become an acknowledged leader in musculoskeletal tumor surgery in this area and a national authority in the field.

Dr. Fred Wood, who worked with Dr. Reckling in the Air Force, joined the staff in 1980. He did sports medicine and hand work, but found academics not to his liking and resigned in 1983 to practice locally. Dr. John Rayhack took over the hand program, but later took an academic position in Florida where he had trained.

Dr. George Richardson completed a fellowship, and in July 1985, was appointed to continue the orthopedic hand service with the late Dr. Michael McElroy at K.U. Also at this time, the author became a "regular" professor and subsequently was assigned supervisor of the V.A. clinical orthopedic service and is also continuing the Cerebral Palsy Clinic at K.U.

As the building facilities and staff have increased, so has the degree of training for the residents. Originally orthopedics was not a distinct section, and its very first teachers were general surgeons. Teaching was primarily didactic to medical students and then interns. The orthopedic rotation in the general sur-

(Continued on page 245)

CLINICAL VIGNETTES

Neurocysticercosis

HENRY R. KUHN, JR., M.D.*; JON A. MORGAN, M.D.*; RUBINA KHAN, M.D.*;
HEWITT C. GOODPASTURE, M.D.† and JERRY D. PETERIE, M.D.†, *Wichita*

NEUROCYSTICERCOSIS is a central nervous system infection with the larval form of *Taenia solium*, the pork tapeworm. It is rarely seen in the United States with only 162 reported cases prior to 1982.¹ We recently have seen two patients who are residents of Kansas with neurocysticercosis.

Case Reports

Patient One: A 14-year-old black female was in good health until two months prior to diagnosis when she developed intermittent, generalized, throbbing headaches. The headaches lasted about an hour, were aggravated by standing, and were partially relieved by acetaminophen. They became more frequent and occurred daily at the time of her initial evaluation (one month prior to diagnosis). On one occasion the symptoms were accompanied by nausea and vomiting, and she reported two episodes of transient hallucinations. She denied any other symptoms.

She was raised in western Kansas and lived with her maternal grandmother who raised pigs. Several relatives also raised pigs, including two aunts whose farms she often visited. She reported a one-day trip to the Mexican-American border prior to this evaluation but otherwise had never been outside the United States. Her symptoms caused frequent absences from school and as a result, her usually above average grades declined. Her past medical history was insignificant and she was on no medications prior to the onset of her symptoms. Her family history was noncontributory.

The physical examination at her initial evaluation was unremarkable. Laboratory studies — including

CBC, urinalysis, and electrolytes — were normal. A computed tomography (CT) scan of her head showed an irregular contrast enhancing mass in the right parietal lobe (*Figure 1*). An arteriogram revealed the mass to be vascular in nature. An astrocytoma was suspected and a craniotomy was performed. Multiple needle and direct biopsies were done but the histological findings revealed only non-specific inflammation. She subsequently developed

The “Clinical Vignettes” series is provided to KANSAS MEDICINE by the Department of Internal Medicine and the Department of Family and Community Medicine at the University of Kansas School of Medicine-Wichita.

a left homonymous hemianopia and had two seizure episodes — one tonic-clonic and the other partial motor. She was placed on phenobarbital and phenytoin with no further seizure activity. The headaches remained unchanged. A followup CT scan showed persistence of the lesion. A right occipital lobectomy was performed revealing a discrete oval lesion that proved to be the larval form of *Taenia solium*. Neurologic examination following the second surgery was significant only for slight anisocoria and left homonymous hemianopia.

Stool studies for ova and parasites and indirect hemagglutination titers for *T. Solium* were negative following the second craniotomy as were soft tissue roentgenograms for calcified intramuscular larvae.

The patient was treated with praziquantel 2 gm/8 hrs for 15 days to ensure eradication of any undetected cysticerci. There were no obvious side effects, and she has since returned to her usual lifestyle.

From the University of Kansas School of Medicine-Wichita.

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†Division of Infectious Disease, UKSM-W.

Address reprint requests to Robert T. Manning, M.D., UKSM-Wichita, 1010 No. Kansas, Wichita KS 67214.

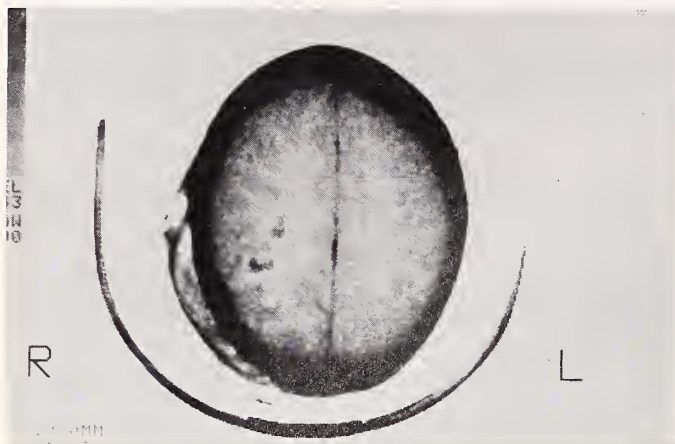


Figure 1. Case one, CT scan showing mass in the right parietal lobe.

Patient Two: A 33-year-old Hispanic female presented with a three-year history of intermittent, generalized, throbbing headaches partially relieved by acetaminophen. Five months prior to admission she developed vertigo accompanied on occasion by transient episodes of loss of consciousness. She denied any other neurologic symptoms.

She had previously been diagnosed as having a brain tumor but had received no further evaluation or therapy. The patient was born and raised in New Mexico and visited Mexico frequently. She admitted to eating uncooked pork on several past occasions. She was on no medications prior to admission.

Her physical examination revealed right lateral nystagmus and left sided papilledema but otherwise

was unremarkable. The CBC and metabolic panel were normal. A CT scan of the brain showed multiple, contrast enhancing cystic lesions adjacent to the ventricles (Figure 2). Magnetic resonance imaging, performed to further delineate the lesions, demonstrated multiple extraaxial cysts compatible with cysticercosis. Soft tissue roentgenograms revealed no calcifications. Indirect hemagglutination studies for *T. solium* were positive.

The patient was placed on Decadron 4 mg 4 times/day and phenytoin 200 mg twice daily as prophylaxis for seizures for two weeks. After the positive serology was obtained, she was treated with praziquantel 1250 mg/8 hrs for two weeks. She tolerated this well, and a followup CT scan (Figure 3) at three months revealed disappearance of most of the lesions and marked decrease in the size of the remaining lesions. Her symptoms resolved, and she returned to her usual lifestyle. She presented 24 months later following a normal pregnancy and delivery with new onset generalized tonic-clonic seizures. Her CT scan demonstrated dilated ventricles suggestive of hydrocephalus. There was no increase in the size of her residual calcified cysts. She was placed on Decadron and experienced rapid resolution of her symptoms. One month later a ventricular shunt was required to provide permanent correction of the hydrocephalus.

Comment

Cysticercosis occurs when a human becomes infected by the larval stage of the pork tapeworm *Taenia solium*. It is usually acquired through the

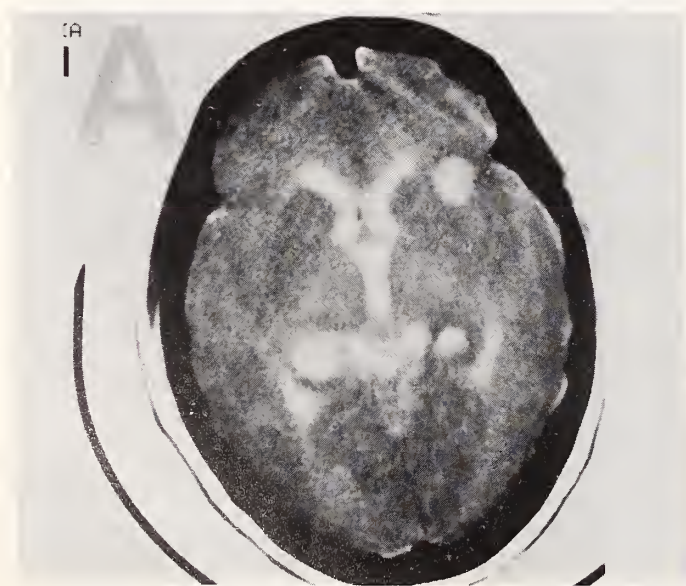


Figure 2. Case two, CT scan showing cystic lesions adjacent to the ventricles.

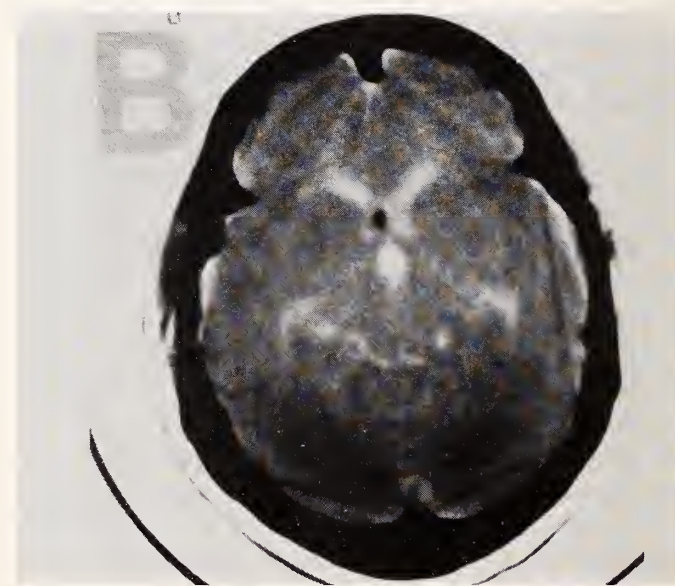
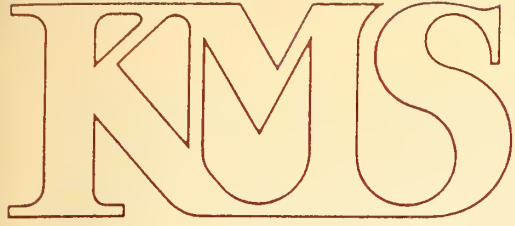


Figure 3. Case two, CT scan three months after treatment was initiated. Most lesions have disappeared and there is marked decrease in the size of those remaining.



KANSAS MEDICAL SOCIETY

Newsletter

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JULY 1987

PROFESSIONAL LIABILITY UPDATE

At press time, the Kansas Supreme Court had still not rendered a decision on the constitutionality of a key part of the KMS tort reform package. At issue is whether or not the Court will strike down a provision that repealed the collateral source rule in medical malpractice cases. The matter has been pending for over 6 months, which is highly unusual, and raises questions about why the Court is having difficulty deciding this issue.

A good bet is that the Court will draft its opinion in such a way as to adversely impact the other parts of the tort reform package, notably the \$250,000 limit on pain and suffering and the total cap on awards of \$1 million. Although every aspect of the tort reform package was drafted carefully in order to meet constitutional scrutiny, it is not a foregone conclusion that the Supreme Court will agree with the Legislature's action. Following the Court's decision, the KMS Executive Committee will evaluate the options available to correct the situation.

An adverse decision by the Supreme Court will only further exacerbate a steadily worsening malpractice situation. With all the tort reform tied up in the courts, not one case has been affected by the reforms; consequently, no relief has been forthcoming. Premiums continue to spiral with no end in sight. Earlier this year, Medical Defense of Springfield, Missouri took a 60% increase, PHICO was granted 35%, and more recently St. Paul was granted a 36% increase. It is expected that Medical Protective will increase its premiums by January 1 of the coming year. Unless the courts allow the reforms adopted by the Legislature to be implemented, premiums will not be stabilized, nor will the continuing crisis be resolved.

Examples of rates some physicians will be paying this year, including the Health Care Stabilization Fund surcharge and coverage for a partnership or corporation, are: OB/GYN--\$62,000; Family Practice, doing OB--\$18,000; Family Practice (no OB) and Pediatrics--\$10,500; General Surgery--\$33,000; Anesthesiology--\$30,000.

KMS continues to monitor the professional liability situation closely, and is committed to achieving a lasting solution to the crisis. All possible options for the future are being reviewed, and should the Court strike down the bulk of the tort reforms enacted over the last two years, significant changes in the malpractice system may be in order, such as abolishing the Health Care Stabilization Fund, repealing the mandatory insurance requirement and accepting a competitive insurance market which provides much lower levels of coverage. In order for KMS to respond to the changing environment, the support and participation of every physician is crucial. As the situation unfolds, KMS will stay in touch with the membership through special mailings and newsletters.

In This Issue...

- Professional liability update
- Exempt license
- Breast cancer booklet
- AMA AIDS action
- Kansas Medicine: Call for papers
- Medicare woes
- KMS/SRS Liaison
- Impaired Physician Program update

EXEMPT LICENSE

Under provisions of SB 36, the Kansas Board of Healing Arts MAY issue an exempt license to a person who has "previously been issued a license to practice the healing arts in Kansas, who is no longer regularly engaged in such practice, and who does not hold oneself out to the public as being professionally engaged in such practice." An exempt license allows a retired physician to maintain a full license to practice medicine, under certain restrictions, stipulations or limitations.

The Board is in the process of establishing rules, regulations and guidelines. When these have been adopted, exempt licenses will be issued to those who qualify. The Board will approve applications on a case-by-case basis.

Those who wish to retain an active license must continue to comply with the requirements for professional liability coverage and continuing education. The person who seeks exempt status must provide the Board with an affidavit pledging s/he will not render professional services as a health-care provider in Kansas. The licensee who is licensed accordingly is exempt from the mandatory insurance and continuing education requirements. The Board will probably discontinue the inactive license.

Questions may be addressed to Charlene K. Abbott, Executive Secretary, at the Board office: Landon State Office Building, 900 S.W. Jackson, Suite 553, Topeka, KS 66612-1256, telephone (913) 296-7413.

BREAST CANCER BOOKLET

In accordance with KSA 65-2836, Kansas Board of Healing Arts has developed an appropriate booklet, entitled "Facts...Options...Choices About Breast Cancer." This booklet was designed to help women with breast cancer evaluate, with their physicians, the medical treatment options available. For a free copy, contact the Board by writing:

Kansas Board of Healing Arts
Landon State Office Building
900 S.W. Jackson, Suite 553
Topeka, KS 66612-1256

or calling: (913) 296-7413.

AMA AIDS ACTION

The AMA House of Delegates, meeting June 23 in Chicago, approved a far-reaching report calling for implementation of 17 specific recommendations aimed at preventing or controlling AIDS. The recommendations addressed concerns that there be a judicious balance between the well-being of HIV-positive patients and the protection of the public health. The adopted policy directs AMA continuously to monitor and analyze developments in AIDS and to update policy and recommendations as directed by advances in knowledge. It was emphasized that physicians should assume the leadership role in educating themselves, their patients and the public. A major thrust of the report is that education must continue to be the major weapon in halting the spread of HIV infection. Individuals in society must assume responsibility for being

well informed and for actions that affect their own health and the health of others. The report also stated the need for concerted and cooperative efforts by all members of society in the fight against AIDS. Among the recommendations adopted were the following:

1. mandatory testing for the AIDS virus for donors of blood and blood fractions, organs and other tissues intended for transplantation; for donors of semen or ova collected for artificial insemination or in-vitro fertilization; for immigrants; and for military personnel;
2. voluntary testing--without regard for ability to pay--should be regularly provided for patients who are from areas with a high incidence of AIDS or who engage in high-risk behavior requiring surgical or other invasive procedures. If the voluntary policy is not sufficiently accepted, the hospitals and medical staffs would be prudent to consider a mandatory program for the institution.
3. develop guidelines to determine under what circumstances AIDS patients or carriers should be reported to public health authorities, and to encourage as much uniformity as possible in protecting their identity, except where the interest of the public health requires otherwise.

KANSAS MEDICINE SEEKS PAPERS ON AIDS

KANSAS MEDICINE devoted the March 1986 issue to the subject of AIDS. Changes in progress since that first special issue warrant reassessment and updating of information on the subject. Undoubtedly, Kansas physicians have obtained more experience with this disease. This is an invitation to submit papers for consideration in the second special AIDS issue of KANSAS MEDICINE.

MEDICARE WOES

It is imperative that you communicate to your congressional representative your experiences, complaints, suggestions and ideas concerning the Medicare program in general, and as it affects physician participation and reimbursement specifically. It is the Congress that sets the parameters for HCFA (Medicare's financing regulatory arm). It is the Congress that establishes the complex formula for MAACs. It is the Congress that is debating the issue of physician DRGs, participation vs. non-participation, assignment and other inequities.

Please remember that you, the physician, are the only real advocate for quality patient care still left in the system. It is your obligation to represent your patients before Congress on health matters, of which reimbursement is a real issue. Congress must hear directly from physicians that a problem really exists. Your medical organizations are doing their part, but your representative needs to hear from you directly.

KMS/SRS LIAISON COMMITTEE

The newly appointed Secretary for the Kansas Department of Social and Rehabilitation Services is Winston Barton, a native of Oklahoma and former Deputy Director of the Oklahoma Department of Human Services. He began his Kansas tenure on July 6, and met with the KMS/SRS Liaison Committee on July 9.

The Committee, chaired by Philip A. Godwin, M.D., Lawrence, is composed of physicians practicing various medical specialties, and SRS staff. Its main purpose is to address jointly the problems associated with the Medicaid/Medikan programs.

At the July meeting, a review of the SRS budget revealed that during the 11 months of FY '87 (July '86-May '87), physicians delivered care to 179,259 Medicaid recipients. The total reimbursement for these services was \$21.7 million. The above totals include the monthly Primary Care Network (PCN) case manager fees.

In-patient hospital services for the same period cost SRS \$59.4 million, and covered 27,221 recipients. This compares to 28,422 recipients and a total cost of \$52.7 million for the full 12 months of FY '86, and indicates a steady increase of in-patient costs. These costs represented the major cost overrun in the medical program and were a major factor necessitating a suspension of Medicaid payments in May and June.

SRS reimburses most physician procedures at the 50th percentile of the 1975 Medicare filed charges. The Committee recommends that all physician fees be reimbursed at the 75th percentile of the current customary and prevailing charges.

Effective July 1, 1987, obstetrical and newborn maximum allowances have been increased--some by 150% to 200%, and will provide reimbursement at the 75th percentile of the 1986 customary fees.

The Committee prioritized rate increases for FY '89 as follows: pathology--reimbursement to be based on CPT-4 codes accepted by Medicare and Blue Shield; anesthesiology; in-patient surgery; office visits; and consultations.

The Committee previously recommended that the SRS FY '89 budget include reimbursement for the appropriate radiological procedures when done in "inappropriate" locations.

IMPAIRED PHYSICIAN PROGRAM

The KMS Impaired Physician Program (IPP) is now under the direction of Tim Scanlan, M.D., Wichita. In his dual role of Committee chairman and Medical Director, Dr. Scanlan will be organizing and directing the professional aspects of the program. KMS has recently signed a contract to conduct all IPP activities for the Board of Healing Arts for the coming year. Laurie Stuewe, R.N., is the Coordinator of the program. Her responsibilities will include the investigative, monitoring and reporting aspects of the program. Val Braun, M.P.A., will continue to provide the overall direction of the program, the next major phase of which will be to offer the program to other (non-physician) licensed professionals.

If you have questions concerning the program or the reporting law, or wish to discuss an impaired colleague, please do not hesitate to contact either Laurie Stuewe or Val Braun. THE PROGRAM IS COMPLETELY CONFIDENTIAL. Call (800) 332-0156.

ingestion of food or water contaminated by the parasite ova. Upon being swallowed, the ova is digested in the acidic gastric environment and an oncosphere is released which penetrates the wall of the jejunum and disseminates hematogenously. Most commonly the oncosphere will lodge in the brain (60-92%), subcutaneous tissues (17.8%), skeletal or heart muscle (8.5%) or the eye (5.1%).¹ During a period of 60-70 days the oncosphere develops into a cysticercus.

Symptoms appear after a latent period of 4-5 years and are due to inflammatory changes induced by the dying larvae.² The most common symptoms are those related to increased intracranial pressure, *i.e.* headaches, nausea, and vomiting (80-98%), and seizures (37-40%).^{3, 4} Other symptoms may include visual disturbances, personality changes, or focal neurologic signs of varying degree.³ The most common physical findings are papilledema and mental status changes.¹ Other signs may include cranial nerve palsies, hyper-reflexia, nystagmus, and focal motor weakness.

The CBC and cerebrospinal fluid (CSF) are, for the most part, non-diagnostic although peripheral or CSF eosinophilia may occur in some instances.¹ When performed with contrast dye, the CT scan will reveal an area of ringlike enhancement due to the vascularity of the cyst wall.¹ The presence of a scolex suggests that the cysticercus is living, whereas its absence suggests that the organism is dead. Magnetic resonance imaging can be used to detect the presence of the scolex, and therefore the viability of the organism and the necessity for treatment.⁵ Skeletal muscle roentgenograms demonstrate calcifications representing degenerated cysts in 10-30% of the cases of CNS cysticercosis.^{2, 6, 7} Indirect hemagglutination is positive in 80-90% of patients with CNS cysticercosis.^{8, 9}

Praziquantel is the only agent known to be effective against the larval form of *T. solium*.¹⁰ Its use is occasionally associated with Jarisch-Herxheimer like reactions which can be prevented by concomitant steroid administration.¹¹

The first patient presented with typical symptoms of neurocysticercosis including headaches and vomiting; the CT scan revealed a contrast enhancing lesion that, in retrospect, was characteristic for larval *T. solium*. She most likely acquired cysticercosis through exposure to the pigs on her family's farms as a result of poor hygiene while she was very young.

This is a highly unusual case as only 11 cases of neurocysticercosis have been reported in U.S. patients with no history of extended travel to indigenous areas.

The second case is more typical of neurocysticercosis in the U.S. The patient had a history of travel to an indigenous area and had typical presenting symptoms including headaches and seizures. Her CT scan revealed lesions highly characteristic of neurocysticercosis and serologic testing was confirmatory. She responded well to praziquantel as demonstrated by followup CT and resolution of her symptoms. The later appearance of hydrocephalus was presumed to be the result of scarring produced by healing paraventricular cysts.

With more immigration from indigenous areas, as well as improved diagnostic methods, neurocysticercosis will become a more commonly diagnosed disease in the United States. It is important to consider this previously rare disease in patients who present with compatible symptoms whether or not there is history of exposure to known indigenous areas.

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PRESIDENT'S MESSAGE

CME: Can It Be Improved?

Goals and objectives, needs and evaluations: What do these terms have to do with the practice of medicine? All physicians need to know the ways we learn best. The above terms and concepts focus on our learning. Most of us have learned randomly and have been proud of our effort. Analysis of the learning process can improve our medical education, and I encourage each of us to do it.

To be accredited, Continuing Medical Education (CME) programs must follow certain guidelines. These guidelines outline the process and are available for you to study. *Goals and objectives* are listed for your information in CME program brochures. For these objectives to have meaning, you must identify your own needs. The sponsoring organization of an accredited program must analyze needs for its own programs, and the results may or may not be appropriate to you as an individual. You must do some needs analysis of your own.

The easiest method of needs analysis is the "comfort scale." This method may be ineffective because you may already have command of the subject that most appeals to you. It is better to attend educational sessions related to the most common diseases or conditions that you deal with in your practice. You may need to analyze your own practice and screen your own charts to determine which conditions or diseases you treat in a competent manner. Your own institution may do this analysis if it sponsors CME programs. New information or information derived from new research is popular as CME material.

Evaluation is difficult for most sponsors and individuals, but I encourage your participation. Be critical of CME programs you attend. Your critique



can make the next program better. Involve yourself in your own evaluations also. Such evaluations include self-study tests and certification tests from which you can learn what areas of medicine you need to study. Remember that your learning should be applicable to your practice of medicine; otherwise, it may be fun, but not very useful. In this age of information explosion, you need to narrow your needs assessment, and evaluation can help you to focus on your learning goals.

A handwritten signature in dark ink, appearing to read "Donald V. Hutton". The signature is stylized with a large initial "D" and a long, sweeping line extending to the right.

President



EDITORIAL COMMENT

Owed to the Virus

(Being the recorded rantings of a recent victim of viral pneumonitis and offered in penance for having discounted the significance of such in the past.)

Say, Imhotep or Asclepius,
Did one of you invent the virus?
Wise you were in times remote
But did either of you pause to note
In scripted scroll or frail papyri
The habits of the naughty viri?

Or you, Hippocrates, old buddy,
When Kosians were feeling cruddy,
Did you harumph in manner cagey,
“Lots around these days” — then sagely,
“No doubt a virus of some sort —
Won’t last long since life is short.”

*Hail to thee, blithe virus,
Plague of a thousand guises
They say you’re but a molecule
Of simple form but manners cruel
That comes in many sizes.*

Hey, Paracelsus, you bombastic,
Noted for your potions drastic,
Relied you on shotgun prescription
Since viral forms defied description?
Did you take the easy out —
Pour on the nostrums when in doubt?

Leonardo, we know that
You had anatomy down pat.
Renaissance man you may have been
But what knew you of pathogen?
Black bile, yellow, blood or phlegm —
You placed your bet on one of them?

*Virus, virus, burning bright
In my chest by day and night —
My wheezing lungs can’t overthrow you —
Will someone please turn up the O₂?*

Leeuwenhoek, ’twas no rebuke
If some considered you a kook.
You lived among minutiae
That caught your microscopic eye,
But of electrons you knew naught
So viruses remained uncaught.

You endless line of human treasure!
You brought us health in growing measure.
How much you did to make us proud,
We strive to join the noble crowd.
From earliest times your feats inspire us
But — WHY DID YOU STICK US WITH THE VIRUS?

*The virus is victor of the man
And I would wish my days to be
Bound each to each by firm immunity.*

L’ENVOI

OK, you’ve had it with self-pity —
Let’s knock off this sorry ditty.
You did survive and all the credit
Goes to others, so forget it.
Your case would hardly warrant headline
And, anyway, you’ve made the deadline.

— D.E.G.



New Law Allows Exempt License

WAYNE T. STRATTON, J.D.,* *Topeka*

ON JULY 1, 1987, the provisions of Senate Bill 36 became effective. Supported by the Kansas Medical Society, this law will allow the issuance of an exempt license under certain conditions.

An exempt license may be issued to a physician who has "previously been issued a license to practice the healing arts in Kansas, who is no longer regularly engaged in such practice, and who does not hold one's self out to the public as being professionally engaged in such practice." The exact activities that the law will allow a holder of an exempt license to perform are not specified, and it is anticipated that the Board of Healing Arts will adopt rules and regulations upon this subject.

Persons who hold such exempt licenses are exempt from the requirement that professional liability insurance be carried and are exempt from the continuing education requirements. A persons who holds an exempt license may apply for a regular license by filing a written application with the board and submitting evidence of satisfactory completion of applicable continuing education requirements established by the Board.

Physicians considering whether to obtain an exempt license must be aware that some of the benefits secured in the Kansas tort laws during the last few years will not be available to them. Provisions short-



Mr. Stratton is legal counsel for the Kansas Medical Society. His discussion topics are selected for their medicolegal interest to physicians. Readers are invited to submit questions or items of interest in this area for attention in this series.

ening the statute of limitations, modifying the evidentiary rules, the use of screening panels, etc., will not apply since the exempt license holders are not health care providers under Kansas law. Most significant is the lack of any protection afforded by liability insurance or by the Health Care Stabilization Fund. While insurers may ultimately offer some insurance package, at the present time none is being written. Any physician holding an exempt license who is liable for any professional act performed during the course of such licensure will be personally liable and, of course, will personally bear the expense of the defense of any claim.

* KMS Legal Counsel.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE or the Kansas Medical Society. For further information, contact Mr. Stratton, 215 E. 8th, Topeka KS 66603, 1-800-332-0248.



KFMC UPDATE

WITH THE 1986 PRO contract, the Health Care Financing Administration (HCFA) implemented generic quality screens. Unfortunately, the design of the generic quality screens and the initial rigid interpretation required by HCFA have resulted in considerable misunderstanding and aggravation to the physicians in most states, including Kansas. This is because HCFA's criteria interpretation has required nonphysician review staff to refer for physician review any chart that does not meet criteria, even if the chart is obviously not a quality issue. Attending physicians and KFMC's physician reviewers have become aggravated in many instances due to these "false-positives" which waste the time of physician reviewers and anger attending physicians with obviously unfounded questions about their care.

Recently, HCFA has softened its attitude somewhat and will allow PROs to use some discretion in making referrals to physician reviewers, *i.e.*, the review staff can approve the chart even though the screen is technically not met. Therefore, we believe many of the problems we have encountered to date will be eliminated.

We acknowledge that KFMC's quality referral form has contributed to the confusion surrounding this issue. On our original physician reviewer worksheet, the disposition of the case was not always clear. Often either "education only" or "no further action" was checked but did not clearly indicate that no quality issue was identified. The "education only" reference also raised the ire of many physicians who felt that they needed no education on the topic. Therefore, we are revising the forms so that a simple statement of "no quality issue" can be marked as the outcome. In addition, we are trying to make appropriate referrals known to attending physicians for their information only, without making any reference to education.

KFMC's formal quality assurance protocol for cases identified as having quality concerns follows the steps outlined below:

1. KFMC staff reviews the medical records and refers questioned cases to the physician reviewers.
2. The initial physician reviewer will review the chart and complete the initial physician reviewer

form with his/her comments and a disposition on the case, *e.g.* no quality concern or further referral necessary. This is a confidential form which is separate from the utilization review worksheet.

3. The initial physician reviewer form is mailed to the attending physician and s/he is given ten days to respond.

4. At the end of the ten-day comment period, a second physician reviewer reviews the chart, taking into consideration any additional information provided by the attending physician. The second physician reviewer may visit with the attending physician, if necessary, before making a final determination. That determination will be documented on a second physician reviewer comment form and, if a quality problem is confirmed, the severity ranking will be included. (The severity of the quality problem is divided into Classes I-IV in increasing severity, based on patient outcome. All Class III and Class IV cases are automatically referred to the Quality Review Board for evaluation at their monthly meeting.)

5. The second physician reviewer comment form is sent to the attending physician. If a quality concern was verified and it is classed as I or II, no further action is taken by KFMC, although the case is logged for profiling purposes. Class III and IV cases are verified by the Quality Review Board.

It is the Quality Review Board's responsibility to meet monthly and decide at what point, if any, sufficient quality problems have been identified for a specific practitioner to warrant corrective action. That corrective action may range from a meeting with the Medical Director and/or Quality Review Board to 100 per cent concurrent review of admissions.

If the attending physician fails to, or is unable to, comply with the corrective action or continues to have similar difficulties, a sanction report may be initiated. I want to point out that KFMC does not take its sanction responsibilities lightly and will not recommend a sanction to the Office of Inspector General unless the Quality Review Board and the full Board of Directors feel it is absolutely necessary.





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Proceedings

(Continued from page 215)

and announced the following tellers: Robert D. Parman, M.D., Topeka, Chairman; Richard A. Gruendel, M.D., Kansas City; and William T. King, M.D., Great Bend.

The results of the election were announced as follows:

PRESIDENT: Donald W. Hatton, M.D., Lawrence

PRESIDENT ELECT: Terry L. Poling, M.D., Wichita

FIRST VICE PRESIDENT: Alex Scott, M.D., Junction City

SECOND VICE PRESIDENT: Roger D. Warren, M.D., Hanover

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AMA ALTERNATE DELEGATE 1987-88: Jay S. Schukman, M.D., Great Bend

AMA ALTERNATE DELEGATE 1987-88: John P. Brockhouse, M.D., Emporia

SPEAKER: Ivan E. Rhodes, M.D., Wichita

VICE SPEAKER: Kenneth L. Derrington, M.D., Shawnee Mission

Thomas L. Taylor, M.D., Chairman of the Reference Committee, presented the Committee's report and recommendations, and the Resolutions were duly discussed and voted upon. They are printed elsewhere in this issue.

Results of Council District elections were announced as follows:

District #1: Norman W. Berkley, M.D., Seneca

District #3: Eugene W. J. Pearce, M.D., Shawnee Mission

District #5: Frank C. Lyons, Jr., M.D., Manhattan

District #8: Larry R. Anderson, M.D., Wellington

District #9: David H. Clark, M.D., Salina

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The Speaker announced that Donald W. Hatton, M.D., is now President. Dr. Hatton expressed his appreciation to the meeting hosts and to the House of Delegates.

Jerry Slaughter pledged that the policies mandated by the House will be carried out. He announced that the license fee for physicians is now \$115. He recognized the work of the AIDS Task Force and noted that its membership includes the following KMS members: Donald W. Hatton, M.D., Lawrence; William J. Reals, M.D., Wichita; Donna E. Sweet, M.D., Wichita; and William E. Wade III, D.O., Topeka.

William J. Reals, M.D., spoke for the Task Force and solicited input, support, and participation from all Kansas physicians.

Rex R. Fischer, M.D., Manhattan, reminded the delegates that a State Meeting can be successfully planned and executed if a number of people are willing to cooperate on behalf of the organization.

The meeting was adjourned at noon.



Resolutions

An asterisk following the resolution number indicates a change in the Constitution and By-Laws.

RESOLUTION NO. 87-1

Expiration of 1982 Resolutions

KMS By-Laws — 5.444

“Official policies established through resolutions at the House of Delegates shall be in effect for a period of five (5) years, at which time that policy position will be reviewed by the Executive Committee and will expire subject to the approval by the House of Delegates unless superseded or continued by another resolution.”

Attached is a copy of the 1982 resolutions which are scheduled to expire this year. Changes in the bylaws shall remain in effect until such time as they are amended by the House of Delegates.

Resolved, That all 1982 resolutions expire.

RESOLUTION NO. 87-2

On-Site PRO Review and Open Reconsideration Hearings

WHEREAS, The KFMC renewed the PRO contract with HCFA; and

WHEREAS, The new contract significantly reduces the number of hospitals eligible for onsite review, and no longer allows physicians to attend reconsideration hearings; and

WHEREAS, These actions place undue administrative burdens on hospitals and physicians, and greatly diminish the physician's ability to clarify issues that may lead to denials or sanctions; therefore be it

Resolved, That the KMS ex-officio members of the KFMC Board of Directors be instructed to support the following:

1. Implementation of onsite review for all hospitals;
2. Reopening of reconsideration hearings to attending physicians through telephone conference calls; scheduling of hearings in local areas; or reimbursement of attending physicians' travel expenses.

RESOLUTION NO. 87-3

PRO Involvement in Quality Review and Physician Sanctions

Resolved, That the KMS ex-officio members of



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the KFMC Board of Directors request the Board to adopt the following policies:

1. Any perceived quality review assessment involving a member of a hospital's organized medical staff be concurrently presented for comment and review by the appropriate committee(s) of the organized medical staff; and

2. The organized medical staff should have the opportunity to make appropriate recommendations for corrections, when it deems that it is applicable, before the PRO shall act on a quality review matter; and

3. The organized medical staff shall act and inform the PRO organization in a reasonable period of time concerning what action, if any, was taken in relation to a perceived quality review problem.

RESOLUTION NO. 87-4

KFMC Physician Reviewers

WHEREAS, The KFMC as the PRO for Kansas is charged with the responsibility of monitoring the quality of care financed through Medicare and Medicaid; and

WHEREAS, The Review Process for inappropriate

care and substandard care appears to be non-uniform in its application; and

WHEREAS, The procedure for evaluating the quality and performance of physician reviewers appears to be inadequate; therefore be it

Resolved, That the Chiefs of Staff, Hospital Administrators, and Utilization Review Coordinators be encouraged to utilize and submit the approved reporting form to the Governing Council-HMSS, to provide an independent analysis of physician reviewer performance.

RESOLUTION NO. 87-5

KFMC Directors and Officers — Tenure

WHEREAS, The KFMC bylaws currently provide that Directors and Officers serve three (3) year terms and are eligible for four (4) consecutive terms; and

WHEREAS, Tenure of this duration leads to stagnation in direction and inhibits the introduction of new and diverse opinions; therefore be it

Resolved, That the KMS ex-officio members of the KFMC Board of Directors request that the Board amend KFMC bylaws to limit the tenure of Directors and Officers to two (2) consecutive three (3) year terms.

RESOLUTION NO. 87-6

Lay Membership — Kansas Foundation for Medical Care

WHEREAS, The KFMC has been designated as the peer review organization for the state of Kansas; and

WHEREAS, Peer review can only be accomplished by physicians reviewing physicians; therefore be it

Resolved, That lay membership on the KFMC Board of Directors be limited to the current representation.

RESOLUTION NO. 87-7

Kansas Foundation for Medical Care — Endorsement

WHEREAS, Continued and active physician involvement is necessary to achieve the intended goals of the Medicare utilization review program; therefore be it

Resolved, That the KMS continue to endorse the Kansas Foundation for Medical Care as the Professional Review Organization for Kansas for the coming year; and be it further

Resolved, That the KMS endorsement be reviewed on an annual basis.



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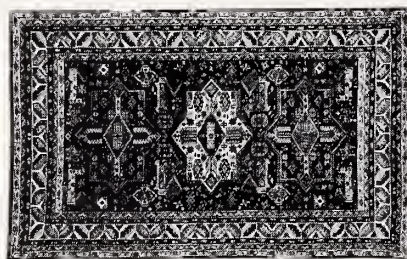
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RESOLUTION NO. 87-8*

Removal of Unpaid Members

Resolved, That section 11.8111 of the bylaws be amended by deleting "July 1" and inserting "June 1."

11.8111 A member remaining in arrears as of *June 1* of that dues-paying year shall be removed from the membership rolls.

RESOLUTION NO. 87-9*

Delegate Allocation

Resolved, That section 11.81 of the By-Laws be amended by deleting "March 15 of each year" and inserting "December 31 of the prior year."

11.81 All dues owed the Society should be remitted before the first of February of each year unless permission for a delay is secured from the President. The remittance may not be delayed beyond the first of April of the same year. The number of delegates of all component societies shall be determined on the basis of information regarding membership available to the state so-

ciety office as of *December 31 of the prior year*; and a list of delegates and alternates shall be submitted to the Executive Director no later than March 20 of each year for the purpose of publishing the names in the program of the annual meeting in May. Assessments are due under the same rule unless special provisions are set by the Council.

RESOLUTION NO 87-10*

Retirement Membership Category

Resolved, That section 1.6122 of the By-Laws be amended by adding: "Retirement status will not be available to physicians who assume compensated positions in the health care field after retiring from medical practice."

1.6122 Retirement: Members who have retired from active practice. Members in this category may hold an inactive license to practice medicine and surgery. *Retirement status will not be available to physicians who assume compensated positions in the health care field after retiring from medical practice.*

RESOLUTION NO. 87-11*

Active Members (Second Year)

Resolved, That the By-Laws be amended by adding new section 1.61111.

1.61111 Active Members (2nd Year): Physicians in the second year of full-time medical practice shall pay 75 percent of regular dues and assessments for the second full dues year.

RESOLUTION NO. 87-12*

Military Service

Resolved, That the By-Laws be amended by adding new section 1.6128.

1.6128 Military Service — Physicians on full-time active duty with the military service. They shall pay fifty percent (50%) of the regular KMS dues and assessments. They shall have the right to vote, but will not be eligible to hold office.

RESOLUTION NO. 87-13

Expansion of Optometric Practice Into Medicine

WHEREAS, Optometrists are not trained adequately to definitively diagnose or treat eye diseases and disorders; and

WHEREAS, There is no need, but there is potential for harm to patients for optometrists to treat eye diseases and disorders; therefore be it

Resolved, That the Kansas Medical Society firmly opposes any and all legislation that expands the scope of optometric practice in Kansas to include the use of therapeutic drugs and/or any surgical modality; and be it further

Resolved, That we strongly encourage our duly elected officials to take appropriate steps to defeat any and all such legislation and protect the eyesight of our citizens.

RESOLUTION NO. 87-14*

Unification

Not adopted.

RESOLUTION NO. 87-15*

AMA Unified Membership

Not adopted.

RESOLUTION NO. 87-16

Tuition at the University of Kansas School of Medicine

WHEREAS, The cost of attending medical school continues to increase; and

WHEREAS, Over three-fourths of 1985 medical school graduates started their careers in debt, with the average loan debt of more than \$30,000; and

WHEREAS, The traditional sources of financial aid for medical students have failed to keep pace with increasing tuition; and

WHEREAS, The \$5770 tuition at the University of Kansas School of Medicine is higher than that at 76% of public medical schools (the national median is \$4200); and

WHEREAS, Over the past five years, the University of Kansas School of Medicine has experienced both a 58% increase in tuition and a 35% decrease in Kansas applicants; and

WHEREAS, This high tuition may cause qualified Kansas applicants to leave the state to study and practice medicine elsewhere; and

WHEREAS, The Kansas Medical Society has a history of supporting financial assistance for medical students, residents, and young physicians; therefore be it

Resolved, That the Kansas Medical Society encourage the Board of Regents and the K.U. Chancellor to place a cap on medical school tuition until such a time as the tuition at the University of Kansas is equal to the national average of state supported medical schools; and be it further

Resolved, That the Kansas Medical Society lend advice and support to the Medical Student Section in developing additional, creative alternatives to traditional sources of medical student financial aid.

RESOLUTION NO. 87-17

KFMC Membership

WHEREAS, There is an increasing need for more physician participation in the PRO program; therefore be it

Resolved, That the KMS ex-officio members of the KFMC Board of Directors request the KFMC Board to develop a program to annually update physicians on PRO activities; and be it further

Resolved, That membership in KFMC be renewed on an annual basis.

(Continued on page 242)

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Respiratory tract infections caused by *Streptococcus pneumoniae* and group A β -hemolytic streptococci (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. Keflet is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of Keflet in the subsequent prevention of rheumatic fever are not available at present.)

Otitis media due to *S. pneumoniae*, *Haemophilus influenzae*, staphylococci, streptococci, and *Neisseria catarrhalis*

Skin and skin structure infections caused by staphylococci and/or streptococci

Bone infections caused by staphylococci and/or *Proteus mirabilis*

Genitourinary tract infections, including acute prostatitis, caused by

Escherichia coli, *P. mirabilis*, and *Klebsiella* sp.

Note: Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

Contraindication: Keflet is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflet.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Usage in Pregnancy:—Safety of this product for use during pregnancy has not been established.

Precautions: *General:*—Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflet occurs, the drug should be discontinued and the patient treated with the usual agents (eg, epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflet may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Keflet should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflet, a false positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest[®] tablets but not with Tes-Tape[®] (Glucose Enzymatic Test Strip, USP, Lilly).

Broad spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B:—The daily oral administration of cephalexin to rats in doses of 250 or 500 mg/kg prior to and during pregnancy, or to rats and mice during the period of organogenesis only, had no adverse effect on fertility, fetal viability, fetal weight, or litter size. Note that the safety of cephalexin during pregnancy in humans has not been established.

Cephalexin showed no enhanced toxicity in weanling and newborn rats as compared with adult animals. Nevertheless, because the studies in humans cannot rule out the possibility of harm, Keflet should be used during pregnancy only if clearly needed.

Nursing Mothers:—The excretion of cephalexin in the milk increased up to 4 hours after a 500-mg dose; the drug reached a maximum level of 4 µg/mL, then decreased gradually, and had disappeared 8 hours after administration. Caution should be exercised when Keflet is administered to a nursing woman.

Adverse Reactions: Gastrointestinal:—Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely. The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Dyspepsia and abdominal pain have also occurred. As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

Hypersensitivity:—Allergic reactions in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson Syndrome, or toxic epidermal necrolysis have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Eosinophilia, neutropenia, thrombocytopenia, and slight elevations in SGOT and SGPT have been reported.

PV 2211 DPP

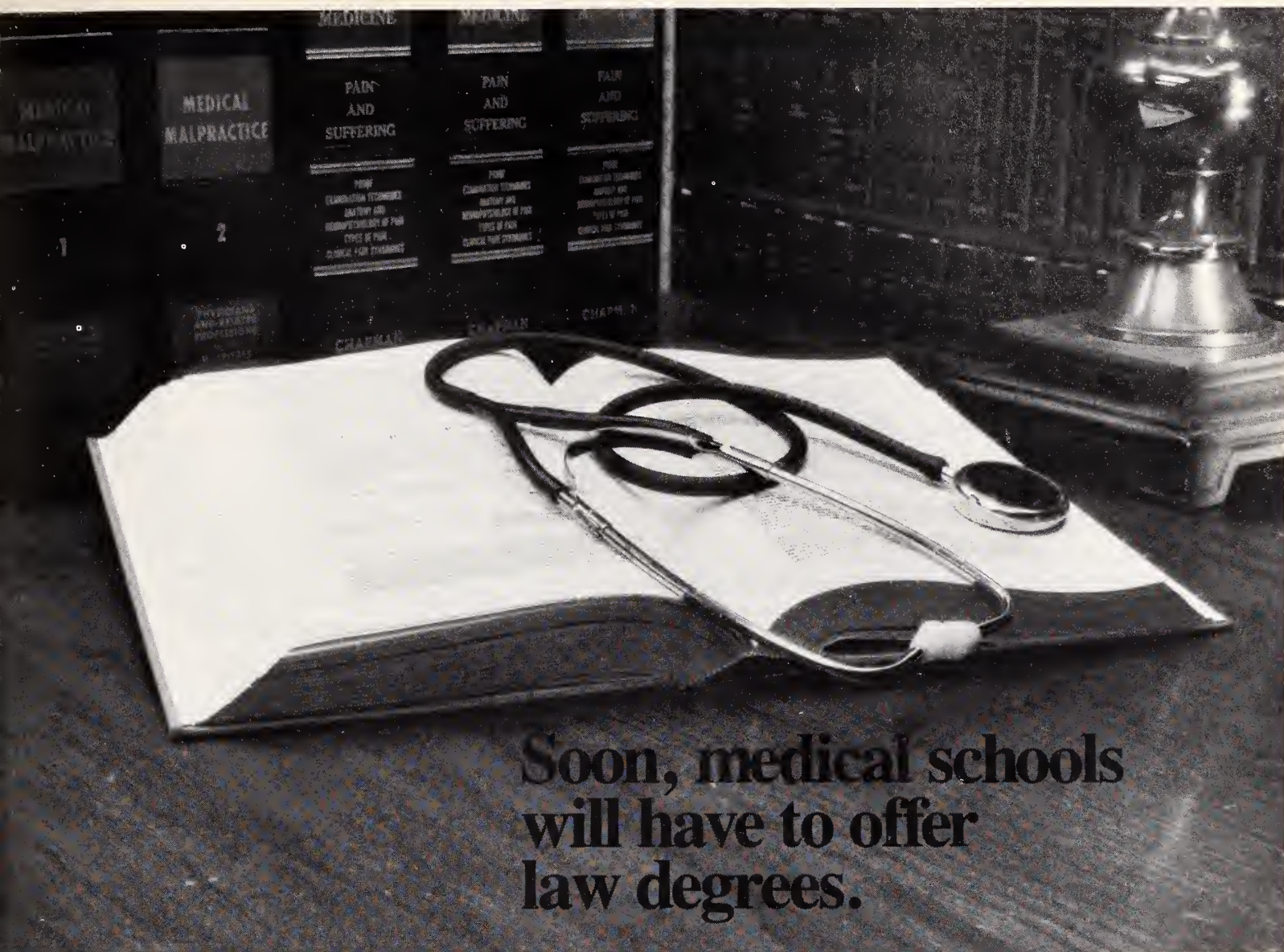
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RESOLUTION NO. 87-18

KFMC Physician Reviewers

Resolved, That the KMS ex-officio members of the KFMC Board of Directors request the KFMC Board to require that physician reviewers must be members of an active medical staff; and be it further

Resolved, That the KMS petition the Health Care Finance Administration to require that all physician reviewers must be members of an active medical staff.

RESOLUTION NO. 87-19

KFMC Risk Management Program for Small Hospitals

WHEREAS, The KFMC has developed a program to assist small hospitals with implementation of the risk management requirements contained in House Bill 2661; and

WHEREAS, The information generated by this program may potentially result in a conflict of interest with the review programs for Medicare and Medicaid; therefore be it

Resolved, That the KMS Executive Committee appoint a subcommittee to study the issue and develop recommendations for alternative risk management programs for small hospitals; and be it further

Resolved, That the KMS Executive Committee offer, through appropriate mechanisms already in place, to the various hospital medical staffs physicians trained in appropriate specialties for the purpose of risk management and quality review of physicians in that hospital setting.

RESOLUTION NO. 87-20

Dispensing of Drugs by Physicians

Not adopted.

RESOLUTION NO. 87-21

Kansas State Board of Healing Arts

Not adopted.

RESOLUTION NO. 87-22

Formation of a Physician-Owned Medical Malpractice Insurance Company

Not adopted; referred for study.

RESOLUTION NO. 87-23

Young Physicians

WHEREAS, Young physicians (40 years old or younger or in practice less than five years) comprise almost 50% of Kansas physicians; and

WHEREAS, The involvement of young physicians in Kansas has not been optimal; and

WHEREAS, Young physicians are keenly interested in becoming involved, but find it difficult to be recognized for leadership positions in local and state societies; and

WHEREAS, There is a significant national interest in getting young physicians involved in both local and state societies; therefore be it

Resolved, That the Kansas Medical Society support the formation of a formal ad hoc committee with representatives from all council districts to consider the type of representation that young Kansas physicians wish in the Kansas Medical Society; and be it further

Resolved, That the Kansas Medical Society fund the administrative costs of this ad hoc committee and its activities for one year; and be it further

Resolved, That the Kansas Medical Society fund an alternate delegate to the American Medical Association Section on Young Physicians for 1987; and be it further

Resolved, That the ad hoc committee submit a report and recommendations for action to the Council in 1988.

RESOLUTION NO. 87-24*

Duties of Councilor — Impaired Physician Committee

Resolved, That the By-Laws be amended by adding new section 8.79.

8.79 He/She will serve as a member of the KMS Impaired Physician Committee during his/her Council tenure.

RESOLUTION NO. 87-25

Use of Term "Chiropractic Physician"

WHEREAS, The Attorney General of the State of Kansas ruled in a decision dated March 5, 1987, that the term "chiropractic physician is misleading to the public as it implies that a chiropractor is licensed to practice beyond the scope of the statutory definition of chiropractic"; and

WHEREAS, That opinion concludes that doctors of chiropractic cannot use the term "chiropractic physician" based on a review of Kansas statutes; and

WHEREAS, The current policy of the Kansas State Board of Healing Arts recognizes and permits chiropractors to use the designation "chiropractic physician"; and

WHEREAS, The Attorney General's opinion and the Board's current policy relating to this subject will be considered by the Healing Arts Board at their meeting on June 19-20, 1987; therefore be it

Resolved, That the Kansas Medical Society endorse the Attorney General's opinion relating to the term "chiropractic physician" and that this position be conveyed to the Healing Arts Board with the recommendation that the Board's current policy regarding this matter be rescinded to comply with the Attorney General's opinion.

RESOLUTION NO. 87-26

Self-Prescription of Controlled Substances

WHEREAS, In 1972, the American Medical Association's Council on Mental Health published the report, "The Sick Physician," calling attention to our humane and ethical responsibilities to address the needs of these individuals; and

WHEREAS, In 1973, this same body proposed model state laws designed to assist state medical governing bodies and state medical societies in the goal of assisting impaired physicians; and

WHEREAS, The proposed model legislation included the prohibition of self-prescription by the physician of controlled substances; and

WHEREAS, The prohibition of self-prescription of controlled substances was not enacted in Kansas until 1986 as part of the medical liability reform legislation known as House Bill 2661 and was subsequently removed by the passage of House Bill 2418 during the 1987 legislative session; and

WHEREAS, The bulk of published intelligent inquiry over the past 15 years into the problems of assisting impaired physicians indicates that impairment by chemical dependency remains a significant problem for a significant number of physicians; and

WHEREAS, Numerous authors have described greater success for intervention programs in locations where the model legislation has been enacted; therefore be it

Resolved, That the KMS House of Delegates recommend to the state legislature that the statutory prohibition against self-prescription of controlled substances by physicians be restored.

RESOLUTION NO. 87-27*

Professional Practices Review Committee

Resolved, That henceforth the KMS Judicial Committee shall be known as the Professional Practices Review Committee; and be it further

Resolved, That all references to the Judicial Committee in the By-Laws, Sec. 9.1 through 9.18, will be changed to reflect the new name designation.

RESOLUTION NO. 87-28*

Associate Membership — Oral Surgeons

Resolved, That Section 1.623 Associate Members, be amended as follows to allow for membership of oral surgeons:

1.62 Members with full privileges except for the right to vote and hold office. They shall apply for membership through a component society but are assessed less than the full amount of dues.

1.623 Associate Members: Physicians who are active members of another state medical society and wish to affiliate with the Kansas Medical Society. They shall pay fifty percent (50%) of the KMS regular dues and assessments.

Oral surgeons with hospital staff privileges, and membership in their respective local, state and national organizations. They shall pay fifty per cent (50%) of the regular KMS dues and assessments.

RESOLUTION NO. 87-29

Optometric Treatment of Eye Disease

WHEREAS, The public welfare is of utmost concern to all members of the Kansas Medical Society; and

WHEREAS, Physicians have had extensive training and responsibility for the treatment of disease, including diseases of the eye; and

WHEREAS, Optometrists are limited-license practitioners with little supervised clinical exposure to the treatment of eye disease; and

WHEREAS, An optometrist's ability to treat eye disease is based principally on only 100 hours of additional classroom study; and

WHEREAS, Referrals by physicians to other practitioners should be based on their individual competence and ability to provide the services needed by the patients; therefore be it

Resolved, That all members of the Kansas Medical Society be encouraged to use careful medical judgment before referring patients to optometrists for treatment of eye disease.

RESOLUTION NO. 87-30

Professional Liability

WHEREAS, A volatile medical professional liability environment is inimical to the physician-patient relationship, and creates problems in access to high-risk services; and

WHEREAS, The efforts of Kansas physicians to reform the tort system held great promise for resolving the liability crisis; and

WHEREAS, The Kansas Supreme Court appears ready to strike down the reforms passed overwhelmingly in 1985 and 1986 by the legislature; and

WHEREAS, The court's anticipated decision will only refuel and intensify the professional liability crisis to the detriment of patient care; therefore be it

Resolved, That the Council and Executive Committee are directed to take whatever steps are necessary to correct and overcome any constitutional barriers to the implementation of needed tort reform; and be it further

Resolved, That the Council is authorized to levy such assessments of the members as are necessary to fund such a program.

RESOLUTION NO. 87-31

Commendation for Rex Stone, M.D.

WHEREAS, Dr. Rex Stone has served faithfully as the Speaker of the House of Delegates of the Kansas Medical Society; and

WHEREAS, His term of office is ending and he has chosen not to seek re-election; and

WHEREAS, The Kansas Medical Society has benefitted from his counsel and leadership over the last five years; therefore be it

Resolved, That the House of Delegates express its sincere thanks and appreciation to Dr. Stone for his service to the Society and transmit Kansas Medical Society's best wishes for his future endeavors.

RESOLUTION NO. 87-32

I Love the "Little Apple" or "Don't Put the Bite on Me" Appreciation of the Riley & Geary County Societies and Auxiliaries

WHEREAS, The Riley and Geary County Medical Societies and their Auxiliaries have provided a slice of Eden in the Little Apple; and

WHEREAS, The variety of programs and events have provided a virtual applesauce of opportunities that has added spice to the occasion; and

WHEREAS, The spirit of cooperation and camaraderie have proven to all present and involved that their efforts have been anything but half-baked; and

WHEREAS, The general consensus of the membership of the House of Delegates is that the moments spent in this meeting have been truly Golden, Delicious, and the entire affair has been a Pippin; therefore be it

Resolved, That the House of Delegates express its thanks and appreciation to the Riley and Geary County Medical Societies and their Auxiliaries for the excellent manner in which they managed and orchestrated the arrangements for this House of Delegates; and be it further

Resolved, That copies of this resolution be forwarded to the Riley and Geary County Medical Societies and their Auxiliaries.

RESOLUTION NO. 87-33

Commendation for Franklin G. Bichlmeier, M.D.

WHEREAS, The 127th year of the Kansas Medical Society has been an exceptional year; and

WHEREAS, The President of the Kansas Medical Society has done an excellent job in handling the problems for the entire membership of the Kansas Medical Society; therefore be it

Resolved, That this House of Delegates of the Kansas Medical Society give a resounding round of applause for a job well done for Dr. Frank Bichlmeier.

RESOLUTION NO. 87-34

Commendation for Louis M. Culp, M.D. and Richard M. Glover, M.D.

WHEREAS, Louis M. Culp, M.D., has ably served the Kansas Foundation for Medical Care as its president from 1978 to 1987; and

WHEREAS, Richard M. Glover, M.D., has ably served the Kansas Foundation for Medical Care as vice president from 1978 to 1987; and

WHEREAS, The architecture of Peer Review was designed far away by designers who had never seen the location, and these two men did their best to modify the plans to create a structure that was as functional and humane as they could make it; and

WHEREAS, The leadership of these individuals made the Kansas Foundation for Medical Care a respected peer review organization; therefore be it

Resolved, That the Kansas Medical Society recognize and commend Dr. Culp and Dr. Glover for their tireless efforts on behalf of Kansas physicians.

RESOLUTION NO. 87-35

Expression of Gratitude to the University of Kansas Medical Alumni Association

WHEREAS, There was a void in time prior to the KMS Auxiliary dinner on the evening of May 1, 1987; and

WHEREAS, This void was pleasantly filled with a complimentary cocktail party provided by the University of Kansas Medical Alumni Association; and

WHEREAS, The party was enjoyed by all in attendance; therefore be it

Resolved, That the KMS send its expression of gratitude to the University of Kansas Medical Alumni Association for the complimentary cocktail party provided on the evening of May 1, 1987 at the 128th Annual KMS meeting in Manhattan, Kansas.



Orthopedic Surgery

(Continued from page 226)

gery residency program was a logical next step. This rotation provided applied practice in fracture work for general surgery residents.

When the orthopedic surgery residency started, one or two people entered the program yearly. Two-person-a-year resident appointments started about 1968, and in the '70s there occasionally were larger classes. During the course of the residency program, the length has increased from three years (after internship) to five years, including one year of general surgery.

In 1979, the new large clinical facility — Bell Memorial Hospital — was opened. Also at this time, the Paul Harrington Memorial was initiated under the direction of Dr. Marc Asher. In 1983 the spine fellowship program was commenced by Dr. Jacobs and volunteer staff, Dr. Roger Jackson.

In 1987, plans are underway to develop a sports medicine program, new offices are under construction, and Dr. Brad Olney has joined the staff in children's orthopedics. He completed his residency at K.U. in 1985, and has completed a fellowship in Melbourne, Australia.

As orthopedics has progressed as a medial speciality, from the small beginning with interested general surgeons, the program has kept pace and is the second largest section in the Department of Surgery at K.U. The program has served the crippled children and general population of the state quite well, has helped train many general surgeons, has filled many orthopedic positions in the area and state, has an outstanding record of its graduates in passing the orthopedic surgery board, and has filled important positions in the military during times of national crises.

Suggested Readings

1. Allen M: *Medicine Under Canvas*. Kansas City, Sosland Press, 1949.
2. *Catalogues*. University of Kansas School of Medicine 1905-06 to 1916-17.
3. Francisco WD: Plaster saints. *J Kans Med Soc* 77:316, 1976.
4. Major RH: *An Account of the University School of Medicine*. Lawrence, University of Kansas Press, 1968.
5. Peltier LF: The division of orthopaedic surgery in the A.E.F. and the Goldthwait unit. *Clin Orthop* 200:45-49, 1985.
6. Runnels JB, Sheldon GP: A pictorial history of Kansas medicine. *Jayhawker, M.D.* Myers Publishing Co., 1961.

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- Sleep improvement in 74% of patients after first h.s. dose²
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- Dramatic first-week reduction in somatic complaints²

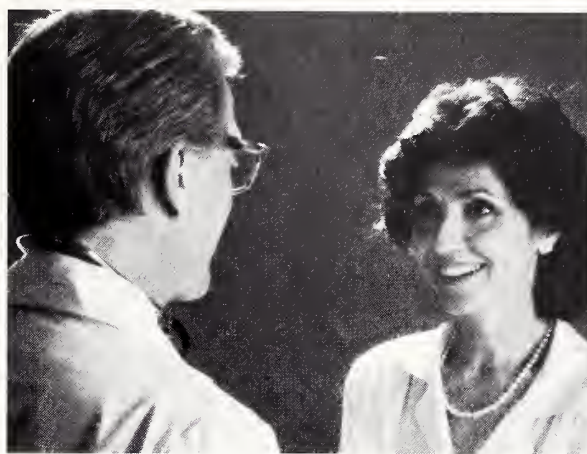
% Reduction in Somatic Symptoms²

Vomiting	Nausea	Headache	Anorexia	Constipation
Reduced 90%	Reduced 86%	Reduced 72%	Reduced 62%	Reduced 60%

- Only 1/3 the dropout rate due to side effects of amitriptyline alone, although the incidence of side effects is similar¹

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

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Protect your decision.
Write "Do not substitute."

In moderate depression and anxiety

Limbitrol[®]

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) ^{IV}

Limbitrol[®] DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) ^{IV}

References: 1. Feighner JP, et al. *Psychopharmacology* 61:217-225, Mar 22, 1979. 2. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

Limbitrol[®] ^{IV} Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring

reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt). Available in bottles of 100 and 500, Tel-E-Dose[®] packages of 100, Prescription Paks of 50.



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and anxiety**

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Each tablet contains 10 mg clordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) 

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Volume 88, Number 8, August 1987 ISSN 8755-0059

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The Kansas Medical Society

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1987

THE JOURNAL OF THE KANSAS MEDICAL SOCIETY



KANSAS MEDICINE

• The Journal Of The Kansas Medical Society •

Volume 88, Number 8, August 1987

Contents

Special Issue: 1987 Membership Directory

Administrative Directory	2
AIDS Alternate Test Sites & Information	6
Alphabetical Listing of Membership	45
AMA Principles of Medical Ethics	121
Codes:	
Medical Schools	40
Medical Specialties	56
Component Medical Societies	20
Genetic Counseling Centers	38
Handicapped Children Referral	15
Hospitals:	
General	29
Home Health Agencies	34
Poison Control Centers	34
State Institutions	34
Veteran & Military	34
Impaired Physician Program Directory	8
Information for Authors	122
Kansas Medical Society:	
Committees	16
Consultants	13
Councilors & Alternates	16
Officers	10
Staff	12
Legislative Contacts	4
Map of County Medical Societies & Council Districts	5
Physician Directory	22
Physician Distribution by Cities	57
Related Organizations	24
Resident Section Membership	117
Specialty Societies	26
Student Section Membership	118
Workers' Compensation Audit Hints	14

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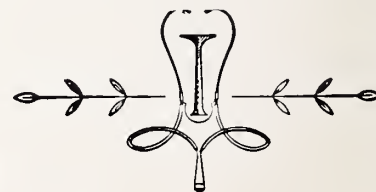
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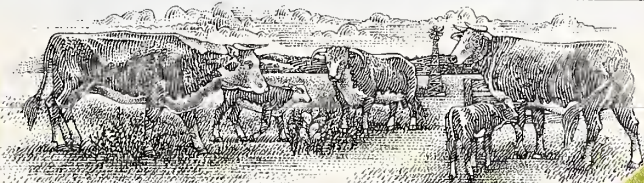
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Good News For People Who Eat.

If your taste buds are not altogether excited about a future of organic fiber flakes, the beef industry would like a few words with you. Even a few from the U.S.D.A. Because the lowdown on beef is probably less than you think—lower in calories, leaner on fat, lighter on cholesterol than you would ever imagine. It's even faster to fix than your mother knows. So read on. And hang on to your forks.



THE LOWDOWN ON CHOLESTEROL

True fact: beef has only 76 milligrams of cholesterol in a 3-ounce serving. That's only average. Wonderfully average.

GOOD NEWS FOR PEOPLE WHO COOK

No sauces, no fussing, no frou-frou. Beef doesn't need much help in the kitchen. To cut time, just cut big things in pieces. With stir-fries, sautees, kabobs and marinades, there's never a dull moment. Or a wasted one.

THIS IS YOUR BITE

3 oz. of lean beef is under 200 calories. But for that fraction of a total day's calories, you get: • 46% of the adult man's RDA for protein • 59% of the adult woman's RDA for protein • 15% of the adult woman's RDA for iron • 40% of the adult RDA for zinc • 76% of the adult RDA for vitamin B-12.

THE UNSATURATION POINT

Over half the fat in beef is actually mono- or poly-unsaturated. That's why 3 ounces of tenderloin have only 3.1 grams of saturated fat out of 7.9 grams total. May your body and your taste buds make peace.

TERIYAKI BEEF STIR-FRY

Preparation: 15 min.

Cooking time: 10 min.

Cut 1 lb. top round steak in thin strips. Marinate in 3 Tbs. teriyaki sauce, 1 Tbs. oil and 2 tsp. cornstarch 30 min. Stir-fry 2 bell peppers (¾" cube) and 6 green onions (2" pieces) in 1 Tbs. oil 3 min.; remove. Stir-fry beef (½ at a time) 2-3 min. Return all ingredients. Cook until hot. 4 servings. Calories: 247 per serving, 162 from beef.

Figures are for 3-ounce servings, cooked and trimmed.

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Beef.

Real Food For Real People.

Source: U.S.D.A. Handbook No. 8-13



ROUND TIP

6.4 gms total fat*
(2.3 gms sat. fat)
162 calories



TOP LOIN

7.6 gms total fat*
(3.0 gms sat. fat)
172 calories



TOP ROUND

5.3 gms total fat*
(1.8 gms sat. fat)
162 calories



EYE OF ROUND

5.5 gms total fat*
(2.1 gms sat. fat)
155 calories



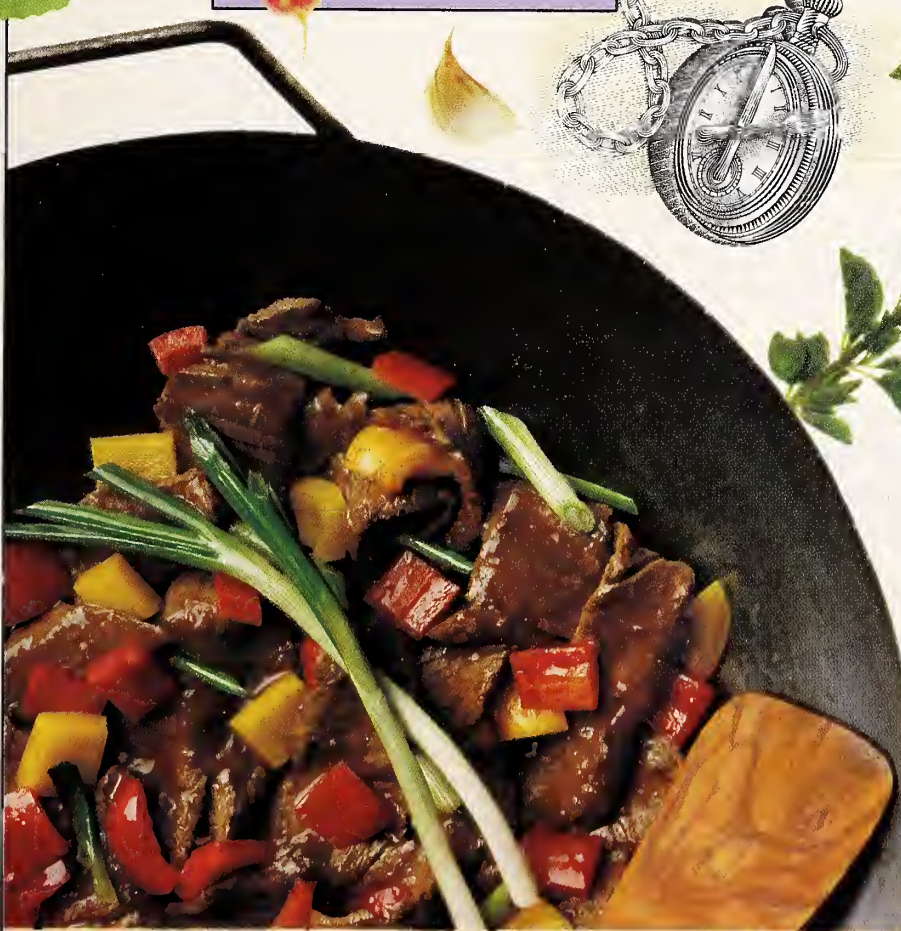
TENDERLOIN

7.9 gms total fat*
(3.1 gms sat. fat)
174 calories



SIRLOIN

7.4 gms total fat*
(3.0 gms sat. fat)
177 calories



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1300 Topeka Avenue, Topeka 66612 913-235-2383
1-800-332-0156

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Wayne T. Stratton, J.D., Legal Counsel 913-233-0593
1-800-332-0248

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20515, (202) 225-6601

Robert Whittaker, 2436 Rayburn House Office
Bldg., 20515, (202) 225-3911

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United States Senate
Address

Dear Senator Doe:

Representatives:

The Honorable John Doe
House of Representatives
Address

Dear Mr. Doe:

THE PRESIDENT

The White House
1600 Pennsylvania Ave., N.W. 20500,
(202) 456-1414

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Topeka, KS 66612

Dear Senator Doe:

Phone: (913) 296-7300

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The Honorable John Doe
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State Capitol Bldg.
Topeka, KS 66612

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To show you how many
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INDERAL[®] LA
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after a major nationwide trial...



...we had
to find
just the
right room.



60,073 patients (90%) who started on INDERAL[®] LA stayed on INDERAL LA.^{1*}

Surprising? Not really.

Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.

A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients² revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol — which shows how well-tolerated once-daily INDERAL LA can be.

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Fifty-nine percent of the time, INDERAL LA stood on its own.

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(PROPRANOLOL HCl) **LONG ACTING CAPSULES**

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*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

The one you know best keeps looking better

Please see next page for brief summary of prescribing information.



The one you know best keeps looking better

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® LA brand of propranolol hydrochloride (Long Acting Capsules)

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T₄ and reverse T₃ and decreasing T₃.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should

be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytin, phenobarbital, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T₃ concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometric tests. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSEAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

REFERENCES:

- INDERAL LA National Compliance Evaluation Program. Data on file, Ayerst Laboratories.
- Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985; 145:1321-1323.

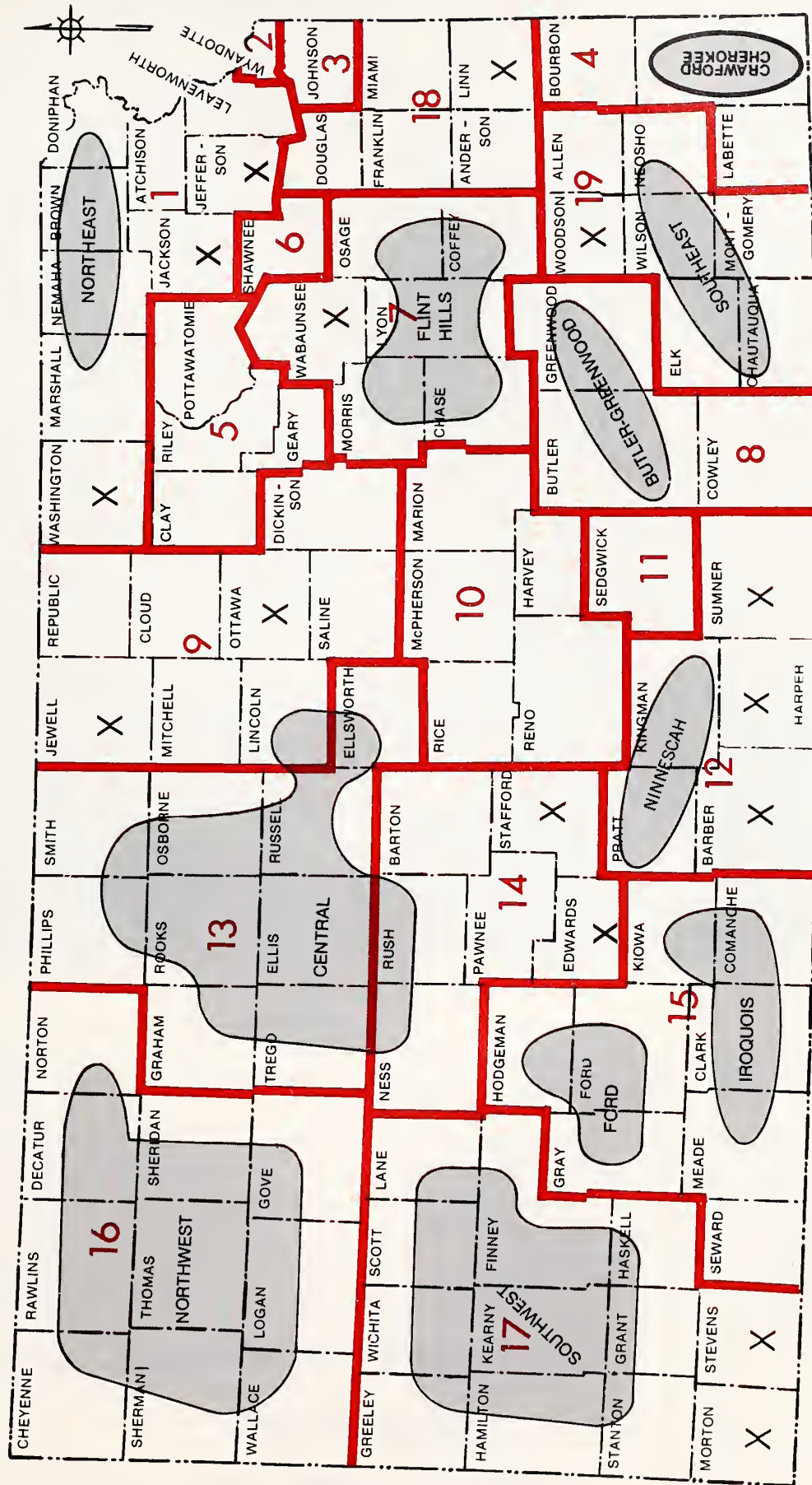
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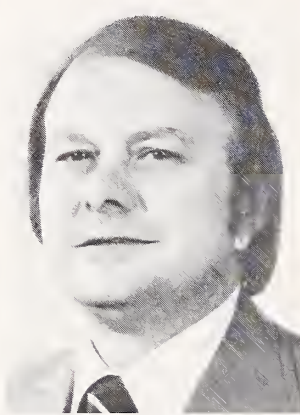
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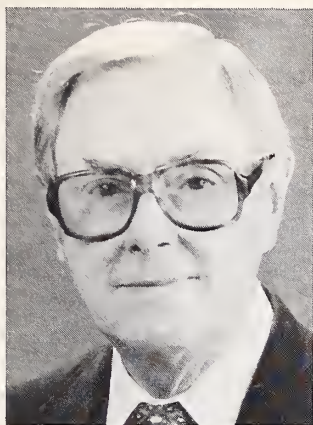
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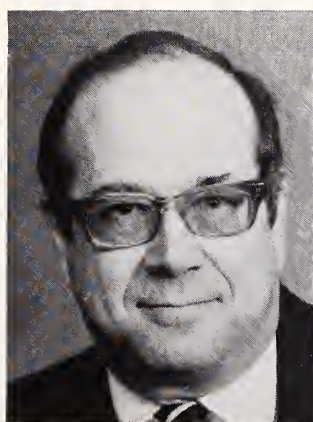
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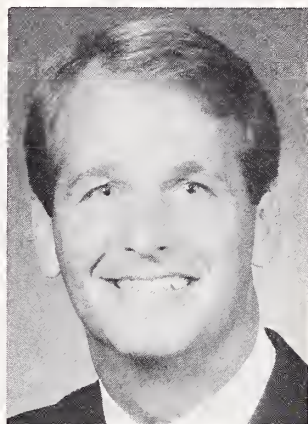


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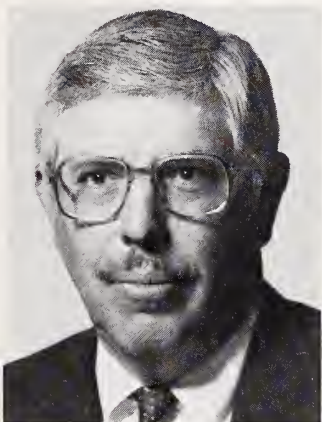


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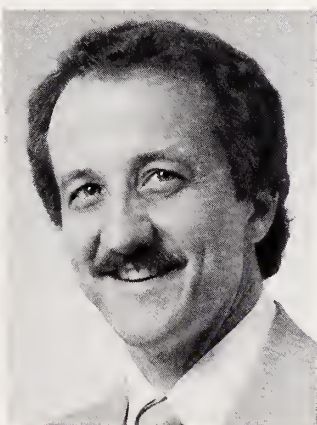


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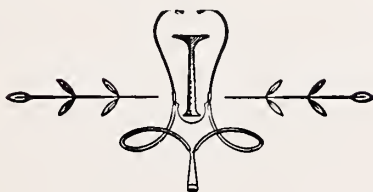
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At the expiration date of your policy year, an audit is made by the insurance company to determine the actual payroll amounts, or other exposures during the year. Following this audit, an adjustment may be made that will require additional premium or a return or credit will be ordered. The following are five tips to assist you in preparing for an audit. The following sources will help the auditor:

1. Payroll journal providing monthly totals and division of payroll by type of work performed.
2. Individual earning records indicating the type of work performed. Gross payroll should be totaled by the quarter.
3. Separate record of overtime shown by employee and totaled by class of work for the policy term involved. (Premium for Workers' Compensation is based on straight time pay for all hours worked and does not include $\frac{1}{2}$ extra pay for overtime.) (Not applicable in Delaware, Pennsylvania, and Utah.)
4. Certificates of Workers' Compensation Insurance for all insured sub-contractors.
5. Social Security (Form 941) and State Unemployment Compensation quarterly returns.

Our auditors are instructed to inform you of the date they intend to call on you or to arrange in advance for a convenient time. To assure accurate assignment of your payroll to the proper classes, it is wise for you to arrange to have someone in your organization familiar with employee job assignments available to work with our auditor during the course of the audit.

If your records are kept by an outside accounting firm, make certain the accountants are aware of the impending visit by the auditor so they will have your records available when needed. In the event the accountant is not well informed regarding the duties of various employees, you may wish to brief him/her in advance of the auditor's visit.

In the audit of your payroll for final billing purposes, you need to determine that the payroll of individual employees is assigned to the appropriate rating classification. This assures that you will be paying the correct premium.

Annual premiums in excess of a specified amount qualify for a discount which varies by state and also by the amount of premium needed to be eligible for the discount. Contact your sales representative if you have any questions about discounts or classifications.



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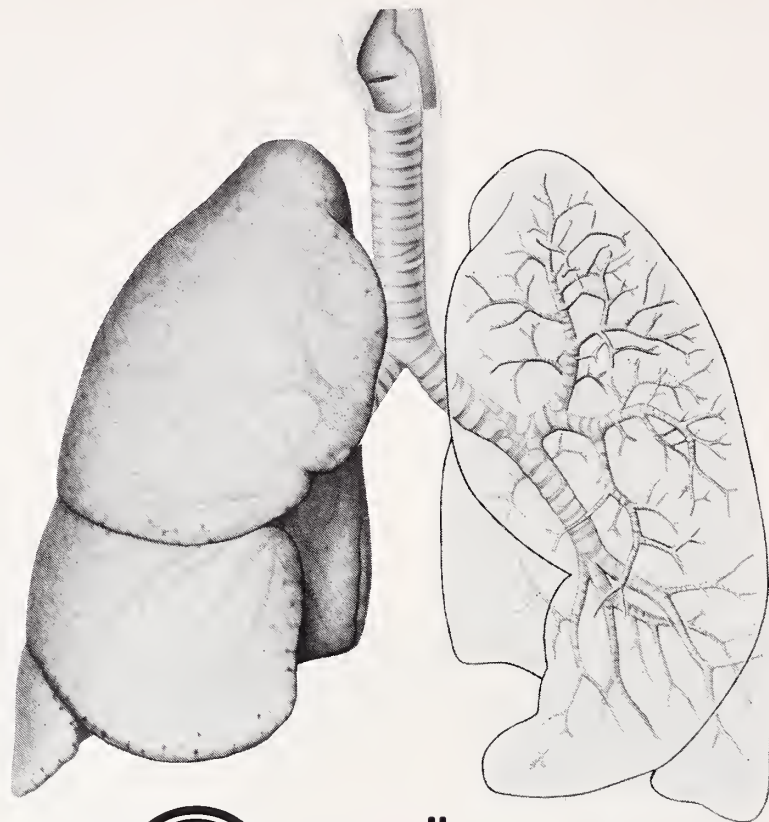


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Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor[®] (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication:
Known allergy to cephalosporins.

Warnings:
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients. Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness,

insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.

- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

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Regional Deaf-Blind Program R	913-296-2062
	913-864-4570
University of Kansas Affiliated Facilities Dx, Tx, S, R, A	
UKSM-Kansas City	913-588-5926
Lawrence	913-864-4950
Parsons	800-362-0390
Headstart Preschools Tx	800-332-0105
Public Schools S, Dx, Tx, R, A	800-332-6262
	913-296-3866
Kansas Ass'n. for Retarded Citizens R, A	913-268-8200
Parent to Parent, Kansas City A	913-648-2317
Families Together, Lawrence R, A	913-841-7241
Kansas Children's Service League R, A	913-232-0543
State Institutions Dx, Tx, R	913-296-3774
Local SRS offices	
Private Facilities:	
Kansas Association of Rehabilitation Facilities	316-284-2330
Other individual listings available through	
<i>Kansas Handicapped Services Directory</i>	913-864-4570



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Before prescribing, see complete prescribing information in SK&F CO. literature or PDR. The following is a brief summary

*** WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions, nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

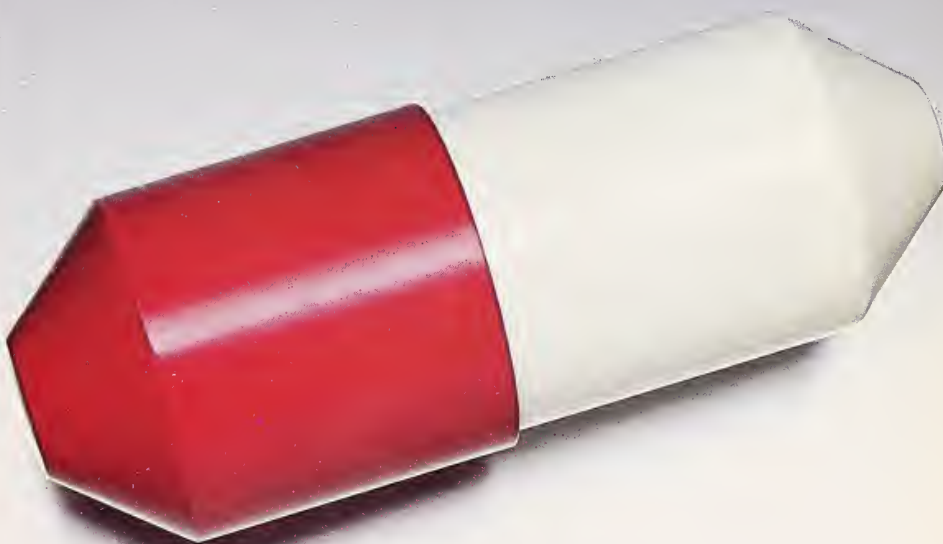
Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for Institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ.L42

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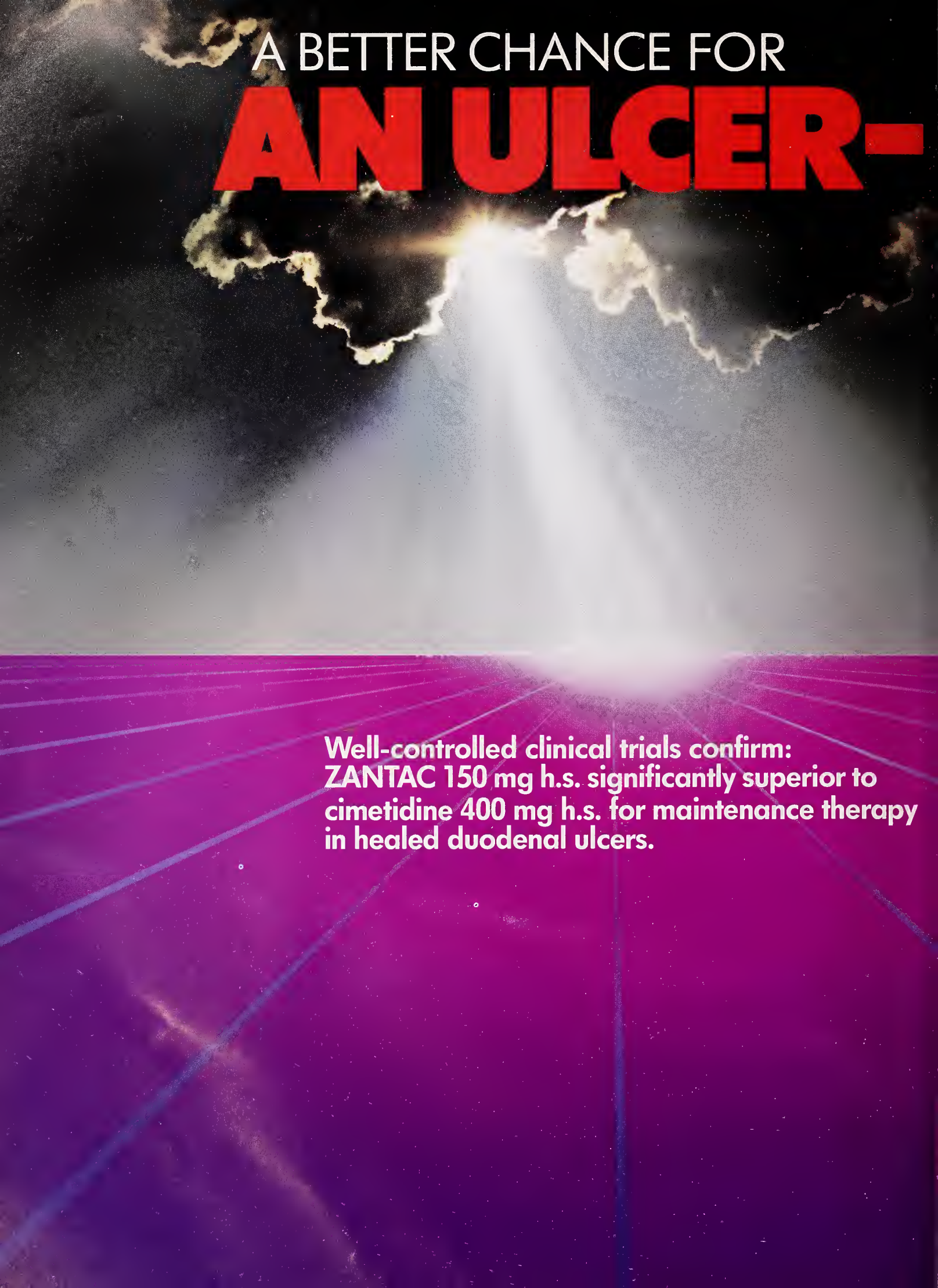
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in healed duodenal ulcers.

FREE FUTURE

Percent of patients ulcer-free after 1 year of therapy

ZANTAC 150 mg h.s. (n = 60)	84%*
cimetidine 400 mg h.s. (n = 66)	57%

ZANTAC 150 mg h.s. (n = 243)	77%†
cimetidine 400 mg h.s. (n = 241)	63%

*P = 0.01 †P = 0.0004 % life-table estimates

All patients were permitted prn antacids for relief of pain. Adapted from Silvis¹ and Gaugh²

These two trials^{1,2} used the currently recommended dosing regimen of cimetidine (400 mg h.s.) and ranitidine (150 mg h.s.). A comparison of other dosing regimens has not been studied.

The studied dosing regimens are not equivalent with respect to the degree and duration of acid suppression or suppression of nocturnal acid.

The superiority of ranitidine over cimetidine in these trials indicates that the dosing regimen currently recommended for cimetidine is less likely to be as successful in maintenance therapy.

Zantac[®] **150** *h.s.*
ranitidine HCl/Glaxo 150 mg tablets

Glaxo / **ROCHE** See next page for references and Brief Summary of Product Information.

ZAN375 July 1987

References: 1. Silvis SE, Griffin J, Hardin R, et al: Final report on the United States multicenter trial comparing ranitidine to cimetidine as maintenance therapy following healing of duodenal ulcer. *J Clin Gastroenterol* 1985;7(6):482-487.
2. Gaugh KR, Karman MG, Bardhan KD, et al: Ranitidine and cimetidine in prevention of duodenal ulcer relapse: A double-blind, randomised, multicentre, comparative trial. *Lancet* 1984;ii:659-662.

ZANTAC® 150 Tablets
(ranitidine hydrochloride)
ZANTAC® 300 Tablets
(ranitidine hydrochloride)

**BRIEF SUMMARY OF
PRODUCT INFORMATION**

The following is a brief summary only. Before prescribing, see complete prescribing information in ZANTAC® product labeling.

INDICATIONS AND USAGE: ZANTAC® is indicated in:

1. Short-term treatment of **active duodenal ulcer**. Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer**. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD)**. Symptomatic relief commonly occurs within one or two weeks after starting therapy and is maintained throughout a six-week course of therapy.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy.

Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see **DOSAGE AND ADMINISTRATION**). Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfasalicylic acid is recommended.

Although recommended doses of ZANTAC do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by same mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Lack of experience to date precludes recommending ZANTAC for use in children or pregnant patients. Since ZANTAC is secreted in human milk, caution should be exercised when administered to a nursing mother.

ADVERSE REACTIONS: Headache, sometimes severe, seems to be related to ZANTAC administration. Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

There have been rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison Syndrome): The current recommended adult oral dosage is 150 mg twice a day. In some patients it may be necessary to administer ZANTAC 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg twice a day.

GERD: The current recommended adult oral dosage is 150 mg twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with ZANTAC, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

ZANTAC® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NDC 0173-0344-42) and unit dose packs of 100 tablets (NDC 0173-0344-47).

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

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October 1986

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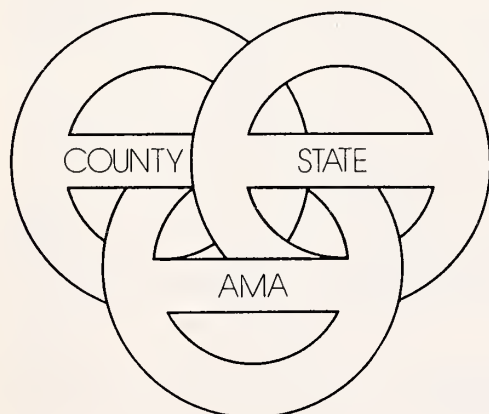
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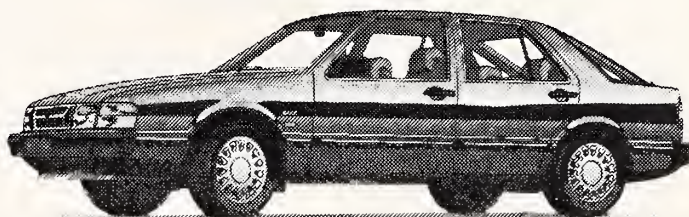
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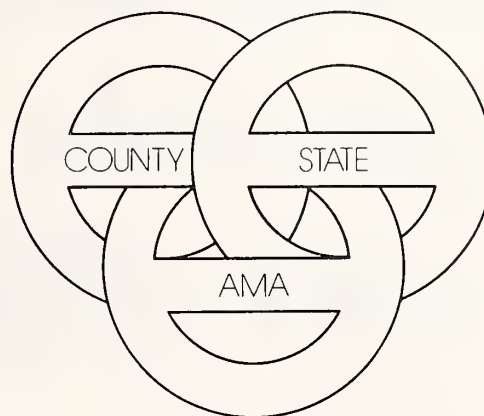
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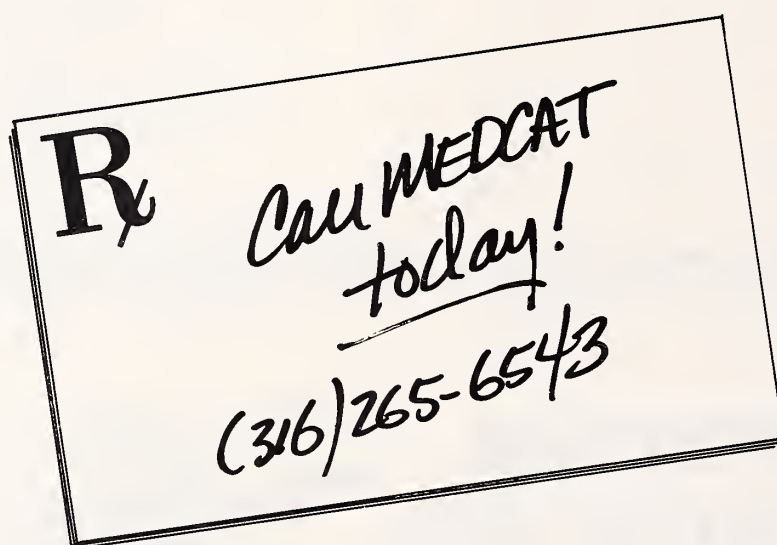
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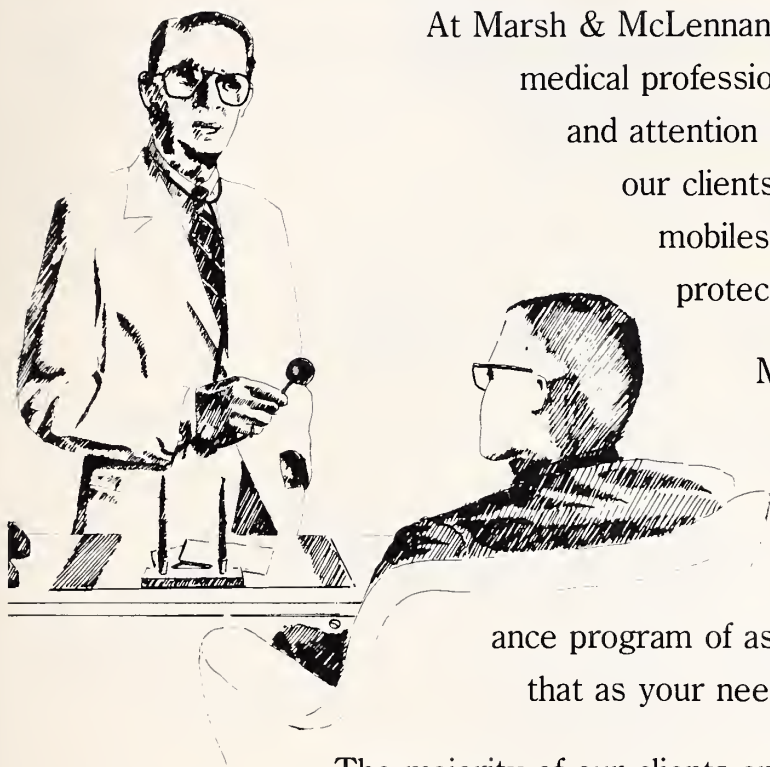
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West Central Ave. 67042 — 316/321-3300
Elkhart — Morton County, P.O. Box 937 67950
— 316/697-2141
Ellinwood — Ellinwood District, 605 North
Main 67526 — 316/564-2549
Ellsworth — Ellsworth County Veterans'
Memorial, Drawer 87 67439 — 913/472-3111
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Chestnut 66801 — 316/343-6800
Emporia — St. Mary's Health Center,
P.O. Box 967 66801 — 316/342-2450
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Sixteenth Street 67045 — 316/583-7451
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Fredonia — Fredonia Regional, P.O. Box 579
66736 — 316/378-2121
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Street 67846 — 316/275-6111
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66032 — 913/448-3131
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Box 5A, 66743 — 316/724-8291
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Medical Center, P.O. Box 540 67735 —
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Walnut 67054-0616 — 316/723-3341
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316/835-2651
Hanover — Washington County District #1,
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Maple 67058 — 316/896-7324

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- Hays** — St. Anthony, P.O. Box 660 67601 — 913/625-7301
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- Hoisington** — Hoisington Lutheran, 250 West Ninth 67544 — 316/653-2114
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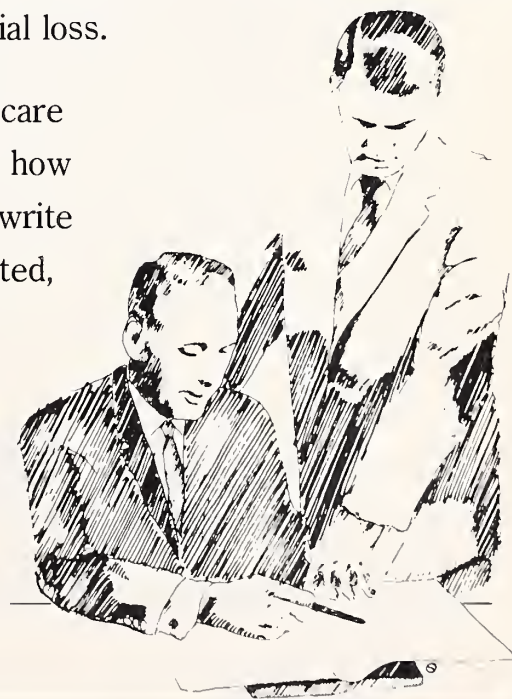


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- Wichita** — Riverside, 2622 West Central Avenue 67203 — 316/945-9161
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Larned — Larned State, R.R. #3, Box 89
67550 — 316/285-2131
Norton — Norton State 67654 — 913/877-3301
Osawatomie — Osawatomie State, P.O. Box 500
66064 — 913/755-3151
Parsons — Parsons State Hospital & Training
Center, P.O. Box 738 67357 — 316/421-6550
Topeka — Kansas Neurological Institute, 3107
West 21st Street 66604 — 913/296-5301
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and Biddle Ave. 66027 — 913/684-5401
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Leavenworth — Veterans Administration
Medical Center, 66048 — 913/682-2000
Topeka — Veterans Administration Medical
Center, 2200 Gage 66622 — 913/272-3111
Wichita — McConnell Air Force Base, USAF
Hospital 67221 — 316/681-5927
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— Day: 316/793-3523; Night: 316/792-2511
Hays — Hadley Memorial Hospital — Day:
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Kansas City — UKSM — 913-588-6633 —
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Night: 913/843-5874
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Salina — St. John's Hospital — 913/827-5591,
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Atwood 67730
Rawlins County, 607 Main — 913/626-3968
Baxter Springs 66713
Baxter Memorial Hospital, 10th & Washington
— 316/856-2314
Beloit 67420
North Central Kansas, 400 W. 8th, Box 217 —
913/738-5175
Burlington 66839
Coffey County, Court House — 316/364-8631
Chanute 66720
Neosho Memorial Hospital, 629 S. Plummer
— 316/431-4000
Clay Center 67432
Clay County, P.O. Box 182 — 913/632-3646
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Montgomery County, City Building, 604 Union
Street — 316/251-4210
Colby 67701
Far Northwest, 210 S. Range, P.O. Box 667
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Columbus 66725
Maude Norton, 220 N. Pennsylvania —
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Concordia 66901
Cloud County, Courthouse, P.O. Box 142 —
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Council Grove 66846

Morris County, Court House — 316/767-5175

Dodge City 67801

Trinity, 1107 6th, P.O. Box 788 —
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Downs 67437

Downs Nursing Center, 1218 Kansas —
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Crossland Rehabilitation Agency, 6111
Leavenworth 66104 — 913/334-2005
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- LABORATORY DIAGNOSIS OF RENAL DISEASE.
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Washington 66968

Washington County, 115 W. 3rd —
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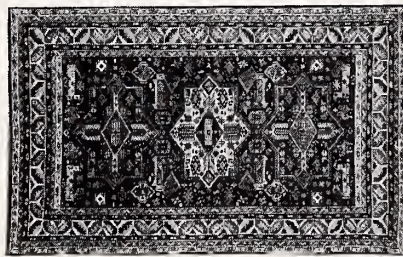
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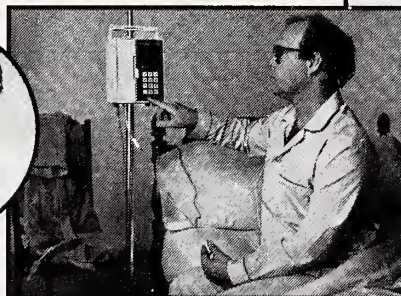
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Pediatrics, UKSM-Wichita, 1010 N. Kansas,
Wichita, 67214 — 316/261-2622

Wichita — Prenatal Diagnosis & Genetic Clinic,
Division of Perinatal Medicine, Wesley
Medical Center/UKSM-Wichita, 550 N.
Hillside, Wichita 67214 — 316/688-2360

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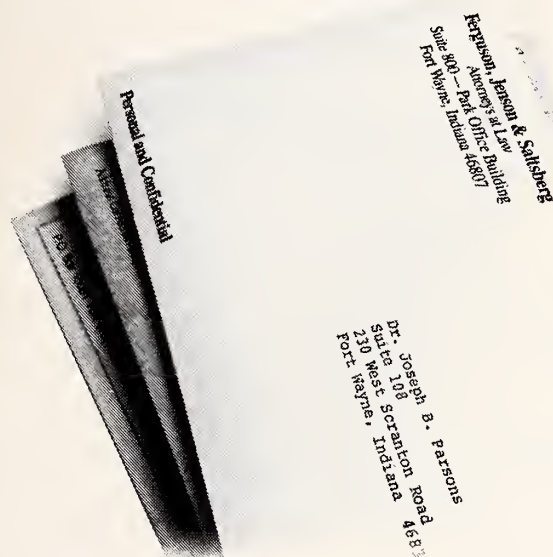
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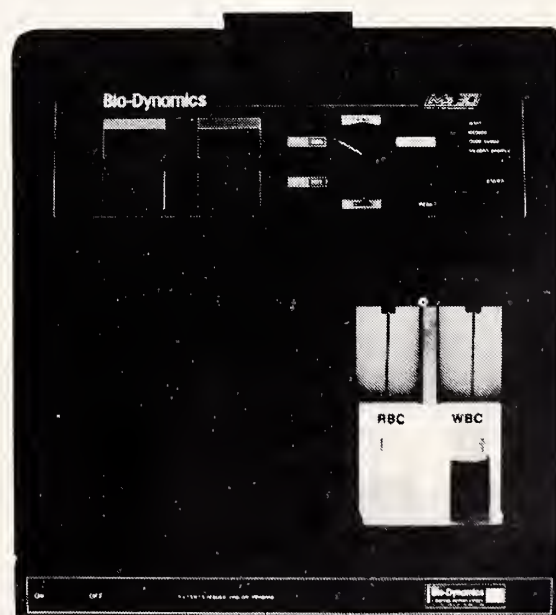
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Medical School Codes

UNITED STATES

- 0102 University of Alabama School of Medicine, Birmingham
- 0301 University of Arizona College of Medicine, Tucson
- 0401 University of Arkansas School of Medicine, Little Rock
- 0502 University of California School of Medicine, San Francisco
- 0506 University of Southern California School of Medicine, Los Angeles
- 0511 Stanford University School of Medicine, Palo Alto
- 0512 Loma Linda University School of Medicine, Loma Linda — Los Angeles
- 0514 University of California School of Medicine, Los Angeles
- 0515 University of California College of Medicine, Irvine
- 0702 University of Colorado School of Medicine, Denver
- 0801 Yale University School of Medicine, New Haven
- 0802 University of Connecticut, Farmington
- 1001 George Washington University School of Medicine, Washington
- 1002 Georgetown University School of Medicine, Washington
- 1003 Howard University College of Medicine, Washington
- 1102 University of Miami School of Medicine, Miami
- 1103 University of Florida College of Medicine, Gainesville
- 1201 Medical College of Georgia, Augusta
- 1205 Emory University School of Medicine, Atlanta
- 1601 Rush Medical College, Chicago
- 1602 University of Chicago Pritzker School of Medicine, Chicago
- 1604 The Hahnemann Medical College and Hospital, Chicago
- 1606 Northwestern University Medical School, Chicago
- 1611 University of Illinois College of Medicine, Chicago
- 1642 Chicago Medical School University of Health Sciences, Chicago
- 1643 Loyola University Stritch School of Medicine, Maywood
- 1645 Southern Illinois School of Medicine, Springfield
- 1676 Chicago College of Osteopathic Medicine, Chicago
- 1720 Indiana University School of Medicine, Indianapolis
- 1803 University of Iowa College of Medicine, Iowa City
- 1875 College of Osteopathic Medicine and Surgery, Des Moines
- 1902 University of Kansas School of Medicine, Kansas City
- 2002 University of Louisville School of Medicine, Louisville
- 2012 University of Kentucky College of Medicine, Lexington
- 2101 Tulane University School of Medicine, New Orleans
- 2105 Louisiana State University School of Medicine, New Orleans
- 2106 Louisiana State University Medical Center, Shreveport School of Medicine, Shreveport
- 2201 Bowdoin Medical School, Brunswick-Portland
- 2301 University of Maryland School of Medicine, Baltimore
- 2307 Johns Hopkins University School of Medicine, Baltimore
- 2401 Harvard Medical School, Boston
- 2405 Boston University School of Medicine, Boston
- 2407 Tufts University School of Medicine, Boston
- 2501 University of Michigan Medical School, Ann Arbor
- 2507 Wayne State University School of Medicine, Detroit
- 2512 Michigan State University College of Human Medicine, East Lansing
- 2604 University of Minnesota Medical School, Minneapolis
- 2701 University of Mississippi School of Medicine, Jackson
- 2802 Washington University School of Medicine, St. Louis

2803 University of Missouri School of Medicine, Columbia
2820 University Medical College of Kansas City
2822 Ensworth Medical College, St. Joseph
2834 St. Louis University School of Medicine, St. Louis
2843 Kansas City College of Medicine and Surgery
2846 University of Missouri School of Medicine, Kansas City
2878 Kansas City College of Osteopathy & Surgery
2879 Kirksville College of Osteopathic Medicine, Kirksville
3005 University of Nebraska College of Medicine, Omaha
3006 Creighton University School of Medicine, Omaha
3007 Nebraska College of Medicine, Lincoln
3305 College of Medicine & Dentistry of New Jersey — New Jersey Medical School, Newark
3401 University of New Mexico School of Medicine, Albuquerque
3501 Columbia University College of Physicians and Surgeons, New York
3503 Albany Medical College of Union University, Albany
3506 State University of New York at Buffalo, School of Medicine, Buffalo
3508 State University of New York College of Medicine, Brooklyn
3509 New York Medical College, New York
3510 Bellevue Hospital Medical College, New York
3515 State University of New York College of Medicine, Syracuse
3519 New York University School of Medicine, New York
3520 Cornell University Medical College, New York
3545 University of Rochester School of Medicine and Dentistry, Rochester
3546 Albert Einstein College of Medicine of Yeshiva University, New York
3547 Mount Sinai School of Medicine of City University of New York, New York
3601 University of North Carolina School of Medicine, Chapel Hill
3605 Bowman Gray School of Medicine, Winston-Salem
3607 Duke University School of Medicine, Durham
3802 Eclectic Medical College, Cincinnati
3806 Case Western Reserve University School of Medicine, Cleveland
3819 Toledo Medical College, Toledo
3840 Ohio State University College of Medicine, Columbus
3841 University of Cincinnati College of Medicine, Cincinnati
3843 Medical College of Ohio at Toledo, Toledo
3901 University of Oklahoma School of Medicine, Oklahoma City
3979 Oklahoma College of Osteopathic Medicine and Surgery, Tulsa
4002 University of Oregon Medical School, Portland
4101 University of Pennsylvania School of Medicine, Philadelphia
4102 Jefferson Medical College of Thomas Jefferson University, Philadelphia
4107 Medical College of Pennsylvania, Philadelphia
4109 Hahnemann Medical College and Hospital, Philadelphia
4112 University of Pittsburgh School of Medicine, Pittsburgh
4113 Temple University School of Medicine, Philadelphia
4114 Pennsylvania State University, Milton S. Hershey Medical Center, Hershey
4177 Philadelphia College of Osteopathic Medicine, Philadelphia
4201 University of Puerto Rico School of Medicine, San Juan
4301 Brown University Division of Biological and Medical Sciences, Providence
4501 Medical University of South Carolina College of Medicine, Charleston
4705 Vanderbilt University School of Medicine, Nashville
4706 University of Tennessee College of Medicine, Memphis
4707 Meharry Medical College School of Medicine, Nashville
4720 East Tennessee State University School of Medicine, Johnson City
4802 University of Texas Medical Branch, Galveston
4804 Baylor College of Medicine, Houston
4812 University of Texas Southwestern Medical School, Dallas
4813 University of Texas Medical School, San Antonio
4814 University of Texas Medical School, Houston
4815 Texas Tech University School of Medicine, Lubbock

4816 Texas A&M University College of Medicine, College Station
 4878 Texas College of Osteopathic Medicine, Ft. Worth
 4901 University of Utah College of Medicine, Salt Lake City
 5002 University of Vermont College of Medicine, Burlington
 5101 University of Virginia School of Medicine, Charlottesville
 5104 Medical College of Virginia Health Sciences Division of Virginia Commonwealth University, Richmond
 5107 Eastern Virginia Medical School, Norfolk
 5404 University of Washington School of Medicine, Seattle
 5501 West Virginia University School of Medicine, Morgantown
 5605 University of Wisconsin Medical School, Madison
 5606 Medical College of Wisconsin, Milwaukee

FOREIGN MEDICAL SCHOOL CODES

CANADA

060 Alberta

06001 University of Alberta Faculty of Medicine, Edmonton
 06002 University of Calgary Faculty of Medicine, Calgary

061 British Columbia

06101 University of British Columbia Faculty of Medicine, Vancouver

062 Manitoba

06201 University of Manitoba Faculty of Medicine, Winnipeg

065 Ontario

06501 University of Toronto Faculty of Medicine, Toronto
 06505 Queen's University Faculty of Medicine, Kingston
 06506 University of Western Ontario Faculty of Medicine, London

067 Quebec

06701 McGill University Faculty of Medicine, Montreal

OTHER FOREIGN

118 Afghanistan

11801 Faculty of Medicine, Kabul University, Kabul

132 Argentina

13201 Facultad de Ciencias Medicas de la Universidad de Buenos Aires, Buenos Aires
 13202 Facultad de Ciencias Medicas de la Universidad Nacional de Cordoba, Cordoba
 13204 Facultad de Ciencias Medicas, Farmacia y Ramos Menores de la Universidad Nacional del Litoral, Rosario, Santa Fe
 13206 Facultad de Ciencias Medicas de la Universidad Nacional de Cuyo, Mendoza, Mendoza

143 Australia

14303 Faculty of Medicine University of Sydney, Sydney, New South Wales

154 Austria

15170 Medizinische Fakultät De U Wien
 15407 Medizinische Fakultät der Universität Wien, Wien (407-26 from March 13, 1938 to June, 1945)

165 Belgium

16501 Faculté de Médecine et de Pharmacie Université libre de Bruxelles, Bruxelles
 16504 Universitaire Katholieke de Louvain, Faculté de Médecine, Louvain

176 Bolivia

17602 Facultad de Ciencias Medicas de la Universidad Mayor Real y Pontificia de San Francisco Xavier de Chuquisaca, Sucre
 17603 Facultad de Medicina de la Universidad Mayor de San Simon, Cochabamba

187 Brazil

18708 Universidade Federal de Parana, Faculdade de Medicina, Curitiba, Parana

209 Burma

20901 Institute of Medicine I, Rangoon

215 Cambodia

21501 Ecole Royal de Medicine Du Cambode, Phnompenh

231 Chile

23101 Facultad de Medicina de la Universidad de Chile, Santiago

242 China

242 China (also see 243 Effective January 1, 1977)
 24209 St. John's University (Pennsylvania Medical School, Shanghai, Kiangsu (Extinct)
 24216 National Shanghai Medical College, Shanghai, Kiangsu
 24217 West China Union University College of Medicine and Dentistry, Chengtu, Szechuan
 24222 Aurora University Faculty of Medicine, Shanghai, Kiangsu (Extinct)
 24239 Shansi University Medical College, Taiyuan, Shansi

243 China

24338 National Honan University Medical College, Kaifeng, Honan (24238 Prior to 1-17-1)
 24351 National Defense Medical Center, School of Medicine, Shanghai, Kiangsu (24251 Prior to 1-17-1)

244 Taiwan

244 Taiwan (Formosa) effective 1-17-1
 24402 College of Medicine National Taiwan University, Taipei (38502 Prior to 1-17-1)
 24404 Taipei Medical College, Taipei (38504 Prior to 11-71)
 24405 China Medical College, Taichung (38505 before 1971)

264 Colombia

26401 Facultad de Medicina de la Universidad Nacional de Colombia Ciudad Universitaria, Bogota, Cundinamarca
 26402 Facultad de Medicina de la Universidad de Cartagena, Cartagena, Bolivar
 26404 Facultad de Medicina de la Pontificia Universidad Javeriana, Bogota, Cundinamarca
 26406 Facultad de Medicina de la Universidad de Caldas, Manizales, Caldas
 26407 Facultad de Medicina de la Universidad del Cauca, Popayan, Cauca

275 Cuba

27501 Facultad de Medicina de la Universidad de la Habana, La Habana
 27502 Escuela de Medicina, Universidad de Oriente, Santiago

286 Czechoslovakia

28601 Deutsche Univerzita Medizinische Fakulta, Praha (15405 before 1919)
 28602 Charles Univerzita Fakulta of PedGen Medicine, Praha

308 Dominican Republic

30801 Facultad de Medicina de la Universidad de Santo Domingo, Ciudad, Trujillo
 30803 Universidad Central Del Este
 30807 Universidad Cetec, Escuela De Medicina, Santo Domingo

319 Ecuador

31901 Facultad de Ciencias Medicas de la Universidad Central, Quito

330 Egypt (United Arab Republic)

33002 Kasr-el-Aini Faculty of Medicine Cairo University, Cairo (Formerly Fouad First University Faculty of Medicine)
 33003 Faculty of Medicine Alexandria University, Alexandria
 33004 Abbasis Faculty of Medicine, University of Ein Shams, Cairo

341 El Salvador

34104 Facultad de Medicina Universidad Nacional del Salvador, San Salvador

352 England

35204 University of Newcastle-Upon-Tyne Medical School (Before August 1963 Kings College University in Durham)
 35205 School of Medicine University of Leeds, Leeds
 35207 University of London Faculty of Medicine, London
 35211 Registrable Qualifications granted by English Conjoint Board (Royal College of Surgeons of England/Royal College of Physicians of London)

385 Formosa (Taiwan)

- 385 (Also see 244 Taiwan [Effective 1-17-1])
38501 Kaohsiung (takau) Medical College, Kaohsiung
38502 College of Medicine National Taiwan University, Taipei
38503 National Defense Medical Center, Taipei
38505 China Medical College, Taichung

396 France

- 39606 Faculte de Medecine de l'Universite de Paris, Paris, Seine
39607 Faculte mixte de Medecine et de Pharmacie de l'Universite de Toulouse, Toulouse, Haute-Garonne

407 Germany

- 407 (Also see 408409—East and West Germany [Effective 1-1-71])
40707 Medizinische Fakultät der Georg-August-Universität, Göttingen, Niedersachsen
40710 Medizinische Fakultät der Universität Heidelberg, Heidelberg, Baden-Württemberg
40715 Medizinische Fakultät der Philipps-Universität, Marburg/Lahn, Hessen
40716 Medizinische Fakultät der Ludwig Maximilians-Universität, München, Bayern
40721 Medizinische Fakultät der Universität Hamburg, Hamburg
40723 Medizinische Fakultät der Johann-Wolfgang-Goethe-Universität, Frankfurt-Am-Main, Hessen
40733 Medizinische Fakultät der Freien Universität Berlin, Berlin

409 Germany West

- 40902 Medizinische Fakultät Rheinischen Friedrich Wilhelms Universität, Bonn (40702 before 1971)
40905 Medizinische Fakultät Albert-Ludwigs-Universität Freiburg IM Breisgau
40921 Medizinische Fakultät Universität Hamburg, Hamburg (40721 before 1971)
40933 Medizinische Fakultät Freien Universität, Berlin, Berlin (40733 Prior to 1-1-71)

418 Greece

- 41801 Faculty of Medicine National University of Athens, Athens
41802 Faculty of Medicine University of Thessaloniki, Thessaloniki

429 Guatemala

- 42901 Facultad de Ciencias Medicas, Universidad de San Carlos, Guatemala

451 Honduras

- 45101 Facultad de Medicina y Cirugia de la Universidad Nacional Autonoma de Honduras, Tegucigalpa

473 Hungary

- 47301 Orvosi Fakultas Tudomanyegyetem, Budapest

495 India (Goa)

- 49501 University of Bombay, Affiliated Medical Colleges are:
a. Grant Medical College Bombay University, Bombay, Maharashtra
b. Seth Gorhandas Sunderdas Medical College Bombay University, Bombay, Maharashtra
49503 Guru Nanak Medical College, Guru Nanak University, Amritsar, Punjab
49504 Madras Medical College Madras University, Madras, Madras
49508 Christian Medical College Punjab University, Ludhiana, Punjab
49509 St. John's Medical College, Bangalore, Mysore (before June 1966: Government Medical College, Mysore University, Mysore)
49511 Andhra Medical College Andhra University, Visakhapatnam, Andhra
49515 Prince of Wales Medical College, Patna University, Bankipore Patna, Bihar
49516 Stanley Medical College Madras University, Madras, Madras
49517 Topiwala National Medical College, Bombay University, Bombay, Maharashtra
49518 Assam Medical College Gauhati University, Dibrugarh, Assam
49521 Osmania Medical College Osmania University, Hyderabad, Andhra
49523 Medical College Baroda University, Baroda, Gujarat
49527 Christian Medical College, Vellore, Madras
49528 Byramjee Jeejeebhoy Medical College, Poona, Maharashtra
49529 Government Medical College Punjab University, Patiala, Punjab
49530 Sawai Man Singh Medical College Rajasthan University, Jaipur, Rajasthan
49531 Medical College Kerala University, Trivandrum, Kerala
49533 Medical College, Bangalore University, Mysore
49534 Gajra Rajo Medical College Vikram University, Gwalior, Madhya Pradesh
49535 Karnatak Medical College Karnatak University, Hubli, Mysore
49536 All-India Institute of Medical Sciences, New Delhi, Delhi
49537 Kasturba Medical College Karnatak University, Manipal, Mysore
49541 G.S.V. Memorial Medical College Lucknow University, Kanpur, Uttar Pradesh
49547 Medical College Jabalpur University, Jabalpur, Madhya Pradesh
49548 M.P. Shah Medical College Gujarat University, Jamnagar, Gujarat

- 49549 Ghandhi Medical College Vikram University, Bhopal, Madhya Pradesh
49550 Guntur Medical College Andhra University, Guntur, Andhra
49552 St. John's Medical College, Bangalore University, Bangalore, Mysore
49554 Rajendra Medical College, Ranchi, Bihar
49555 Sardar Patel Medical College, Bikaner
49557 Kakatiya Medical College, Warangal, Andhra Pradesh
49568 College Medicine Sciences Banaras Hindu University, Varanasi, Uttar Pradesh
49573 Armed Forces Medical College, Poona
49576 Municipal Medical College, Gujarat University, Ahmedabad, Gujarat
49596 Lokmanya Tilak Mun Medical College, Bombay University, Bombay, Maharashtra
49597 Dr. Vaishampayan Memorial Medical College, Shivaji University, Shalapur, Maharashtra
49610 M.L.B. Medical College, Juansi

496 India

- 49611 Sri Krishna Medical College, Muzaffarpur, Bihar

506 Indonesia

- 50602 Faculty of Medicine Airlangga Airlangga University, Surabaya

517 Iran

- 51701 Faculty of Medicine University of Teheran, Teheran
51703 Faculty of Medicine, Tabriz

528 Iraq

- 52801 Faculty of Medicine Baghdad University, Baghdad

539 Ireland

- 53901 Faculty of Medicine Queen's University of Belfast, Belfast
53902 National University of Ireland, Constituent Colleges are:
a. Faculty of Medicine University College, Dublin
b. Faculty of Medicine University College, Cork
c. Faculty of Medicine, Galway

- 53903 School of Physic Trinity College University of Dublin, Dublin

550 Israel

- 55001 The Hebrew University-Hadassah Medical School, Jerusalem

561 Italy

- 56101 Facolta di Medicina e Chirurgia dell'Universita di Bologna, Bologna
56115 Facolta di Medicina e Chirurgia dell'Universita di Perugia, Perugia
56119 Facolta di Medicina e Chirurgia dell'Universita di Siena, Siena

572 Japan

- 57211 Tokyo Medical College (Nippon Ikadaigaku) Hongo, Tokyo (Extinct)
57241 Faculty of Medicine Shinshu University, Matsumoto, Nagano
57249 Tokyo Medical College, Tokyo

583 Korea (South)

- 58301 Severance Medical College Yonsei University, Seoul
58302 College of Medicine Seoul National University, Seoul
58303 Korea University Medical College, Seoul
58304 College of Medicine Kyong-Puk National University, Taegu
58306 College of Medicine Chun Nam National University, Kwangju
58309 College of Medicine Pusan National University, Pusan
58310 College of Medicine Catholic University, Seoul

605 Lebanon

- 60501 Medical School American University of Beirut, Beirut

627 Malta

- 62701 Faculty of Medicine and Surgery Royal University of Malta, Valetta

649 Mexico

- 64901 Facultad de Medicina de la Universidad Nacional Autonoma de Mexico, Mexico
64902 Facultad de Medicina de la Universidad de Nuevo Leon, Monterrey, Nuevo Leon
64906 Facultad de Medicina de la Universidad Nacional del Sureste, Merida, Yucatan
64914 Facultad de Medicina de la Universidad Autonoma de Guadalajara, Guadalajara, Jalisco
64933 Universidad Autonoma de Ciudad Juarez, Ciudad Juarez, Chihuahua
64936 Centro de Estudios Universidad Xochicalo A.C., Cuernavaca, Morelos

660 Netherlands

- 66061 Faculteit der Geneeskunde Universiteit Van Amsterdam, Amsterdam

671 New Zealand

- 67101 Medical School University of Otago, Dunedin

704 Pakistan

- 70401 King Edward Medical College, Lahore, West Pakistan
70402 Dow Medical College, Karachi, Federal Capital Area
70403 Dacca Medical College, Dacca, East Pakistan
70404 Nishtar Medical College, Multan, West Pakistan
70409 Khyber Medical College, Peshawar, North-West Frontier Province

70410 Chittagong Medical College, Chittagong, East Pakistan (16001 after 7-1-72)

726 Paraguay

72601 Facultad de Medicina de la Universidad Nacional de Asuncion, Asuncion

737 Peru

73701 Facultad de Medicina de San Fernando de la Universidad Nacional Mayor de San Marcos, Lima

73705 Facultad de Medicina de la Universidad Nacional de San Agustin, Arequipa

73706 Facultad de Medicina "Cayetano Heredia" de la Universidad Peruana de Ciencias Medicas y Biologicas, Lima

748 Phillipines

74801 Faculty of Medicine and Surgery University of Santo Tomas, Manila

74802 College of Medicine University of the Phillipines, Manila

74807 College of Medicine Manila Central University, Manila

74808 Institute of Medicine Far Eastern University, Manila

74809 College of Medicine Southwestern University, Cebu City

74810 College of Medicine University of the East, Quezon City

74811 College of Medicine Cebu Institute of Technology, Cebu City

759 Poland

75903 Warsaw Medical Academy

75911 Akademia Medyczna, Bialystock

803 Scotland

80301 Faculty of Medicine University of Aberdeen, Aberdeen

80302 University of St. Andrews School of Medicine, Dundee

80303 Faculty of Medicine University of Edinburgh, Edinburgh

80305 Faculty of Medicine University of Glasgow, Glasgow

836 South Africa

83601 Medical School University of the Witwatersrand, Johannesburg

847 Spain

84701 Facultad de Medicina de la Universidad de Barcelona, Barcelona

84703 Facultad de Medicina de la Universidad de Grenada, Grenada

84704 Facultad de Medicina de la Universidad de Madrid, Madrid

84706 Facultad de Medicina de la Universidad de Zaragoza, Zaragoza

84708 Facultad de Medicina de la Universidad de Valencia, Valencia

84710 Facultad de Medicina de la Universidad de Salamanca, Salamanca

84711 Facultad de Medicine de la Universidad Catolica Navarra, Pamplona

869 Switzerland

86901 Medizinische Fakultat der Universitat Basel, Basel

86902 Medizinische Fakultat der Universitat Bern, Bern

86905 Faculte de Medecine de l'Universite de Lausanne, Lausanne

875 Syria

87501 Faculty of Medicine Damascus University, Damascus

Taiwan (See Formosa)

891 Thailand

89101 Faculty of Medicine at Chulalongkorn Hospital University of Medical Sciences, Bangkok

89102 Faculty of Medicine at Sariraj Hospital University of Medical Sciences, Thonburi

89104 Faculty of Medicine at Ramathibodi Hospital, Mahidol University, Bangkok

902 Turkey

90201 Tip Fakultesi Istanbul Universitesi, Istanbul

90205 Hacettepe University Faculty of Medicine, Ankara

913 Union of Soviet Socialist Republics

91302 Voronez Medical Institute, Voronez

917 United Kingdom-England-Wales

91707 University of London Faculty of Medicine, London (35207 before 1971)

941 Viet-Nam South

94101 Faculte mixte de Medicine et de Pharmacie Universite de Saigon, Saigon

957 Yugoslavia

95702 Medicinski Fakultet Univerziteta u Beogradu, Beograd



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Alphabetical Listing

NOTE: Out-of-state members are listed alphabetically but not in the city listings. For addresses of out-of-state members, call the KMS office, 1-800-332-0156.

A

ABAY MD,EUSTAQUIO O, WICHITA
 ABBAS MD,DILAWER H, WICHITA
 ABBO MD,GORDON E, TOPEKA
 ABBUEHL MD,DON R, CHANUTE
 ACEVEDO MD,ALFREDO, WICHITA
 ADAMS JR MD,MARCUS W, HUTCHINSON
 ADAMS MD,ALAN W, OAKLEY
 ADAMS MD,DWIGHT, OSAGE CITY
 ADAMS MD,JOYCE A, KANSAS CITY
 ADAMS,MARY E, KANSAS CITY
 ADKISSON,WAYNE O, KANSAS CITY
 AGIAR,MARY C, KANSAS CITY,MO
 AGUSTIN MD,CONRADO M, WICHITA
 AHLSTRAND MD,RICHARD A, WICHITA
 AHMAD MD,ABDU Q, EL DORADO
 AHMED MD,IFTEKHAR, KANSAS CITY,MO
 AHNEMANN,JANET L, KANSAS CITY
 AILLON MD,ALEJANDRO J, HALSTEAD
 AKERS MD,GUY I, FORT SCOTT
 ALBERS MD,ROBERT C, HAYS
 ALBRIGHT MD,JEROLD D, HUTCHINSON
 ALDERMAN,LILLIAN C, KANSAS CITY
 ALDIS MD,HENRY, FORT SCOTT
 ALDIS MD,WILLIAM, FORT SCOTT
 ALDOROTY MD,NEIL, WICHITA
 ALEXANDER JR MD,L GEORGE, KANSAS CITY
 ALEXANDER MD,ELIZABETH, WICHITA
 ALFONSO MD,MANUEL, WICHITA
 ALGIE MD,WILLIAM H, KANSAS CITY
 ALIFANO,CONNIE L, KANSAS CITY
 ALLBRITTEN JR MD,FRANK F, CUNNINGHAM
 ALLEGRE MD,ANN, KANSAS CITY
 ALLEN EXEC DIR ,DWIGHT, WICHITA
 ALLEN MD,MONTE L, SALINA
 ALLEN MD,FRANCES A, NEWTON
 ALLEN MD,JAMES E, TOPEKA
 ALLEN MD,MARK L, KANSAS CITY,MO
 ALLEN MD,MAX S, SHAWNEE MISSION
 ALLEN MD,PHILLIP M, WICHITA
 ALLEN MD,RAY E, LIBERAL
 ALLEN SR MD,WILLIAM R, KANSAS CITY
 ALLEN,JR MD,WILLIAM R, KANSAS CITY
 ALLEY,ROBYN R, KANSAS CITY
 ALLIN MD,DENNIS M, KANSAS CITY,MO
 ALMONTE MD,PRISCILLA C, WICHITA
 ALMONTE MD,RODOLFO O, WICHITA
 ALQUIST MD,VERYL D, BAXTER SPRINGS
 ALSOP MD,WILLIAM R, SALINA
 ALTENBERND MD,ELVIN CONRAD, SHAWNEE MISSION
 AMAWI MD,MOHAMMAD S, DODGE CITY
 AMBLER MD,CARL D, PRATT
 AMEND MD,DOUGLAS J, EMPORIA
 AMMAR MD,ALEX D, WICHITA
 AMSTUTZ MD,SAMUEL W, WICHITA
 ANDERSON MD, EUGENE G, GREEN VALLEY,AZ
 ANDERSON MD,DALE W, AUGUSTA
 ANDERSON MD,DAVID J, WICHITA
 ANDERSON MD,JAMES D, WICHITA
 ANDERSON MD,JODY, SALINA
 ANDERSON MD,LARRY R, WELLINGTON
 ANDERSON MD,LYLE B, BLOOMINGTON,IN
 ANDERSON MD,SEVERT A, CLAY CENTER
 ANDERSON MD,WILLIAM A, SHAWNEE MISSION
 ANDERSON MD,WINSTAN L, SUN CITY WEST,AZ
 ANTHONY,THOMAS, KANSAS CITY
 ANTRIM MD,PHILIP JENIFER, ANTHONY
 APPENFELLER MD,WILLIAM O, OSAWATOMIE
 APPELEGATE JR MD,FRANCIS R, HAYS
 ARAFILES MD,ESTHER D N, OSKALOOSA
 ARAKAWA MD,KASUMI, KANSAS CITY
 ARGOSINO MD,RODOLFO, WICHITA
 ARJUNAN MD, K N, TOPEKA
 ARMERUSTER MD,ALBERT A, SHAWNEE MISSION
 ARMSTRONG MD,HAROLD J, PITTSBURG
 ARMSTRONG MD,JEFFREY A, KANSAS CITY
 ARNOLD,KATHLEEN J, WICHITA
 ARONOFF MD,MICHAEL E, OLATHE
 ARONSON,RITA K, ROCK ISLAND,IL
 ARPIN MD,JEFFREY P, LEAVENWORTH
 ARROYO MD,ZEFERINO, GARDEN CITY
 ARTZ MD,TYRONE D, WICHITA
 ARUNAKUL MD,PUNYA, TOPEKA
 ASH,LISA M, KANSAS CITY,MO
 ASHBURN MD,WILLIAM T, WICHITA
 ASHER MD,MARC A, KANSAS CITY
 ASHKAR MD,ADNAN, LEAVENWORTH
 ASHLEY JR MD,B JOHN, TOPEKA
 ASHLEY MD,BYRON J, TOPEKA
 ASHLEY MD,SAMUEL G, CHANUTE
 ATKIN MD,J D, YATES CENTER
 ATKINS,JEFFREY A, SHAWNEE MISSION
 ATLURU MD,NARAYANA RAO, TOPEKA
 ATWOOD MD,LARRY C, INDEPENDENCE
 ATWOOD MD,M DALE, KINSLEY
 ATWOOD MD,MICHAEL D., TOPEKA
 AUCAR MD,ALFREDO, ARKANSAS CITY
 AUNINS MD,JOHN, WICHITA
 AUSTIN MD,JOHN O, GARDEN CITY

B

AUSTIN MD,KENNETH D, GOODLAND
 AVERILL MD,STUART C, TOPEKA
 AVES MD,AGNES, PARSONS
 AVES MD,RENATO B, PARSONS
 AVILA MD,OSCAR A, DODGE CITY
 AYUTHIA MD,ISSARA I, DODGE CITY
 AZIZ MD,SAIF A, WICHITA
 BABER MD,JAMES W, WICHITA
 BACANI MD,OSWALDO, FREDONIA
 BACHMAN MD,GREG R, WICHITA
 BACKES MD,DAVID J, WICHITA
 BACON MD,ARTHUR H, LAKE WORTH,FL
 BADEEN II MD, LOUIS JOHN, SHAWNEE MISSION
 BAEHR MD,RALPH H, TOPEKA
 BAEKE MD,JOHN O, SHAWNEE MISSION
 BAILEY MD,WILLIAM A, LAWRENCE
 BAILEY,MICHAEL J, HALSTEAD
 BAIR MD,ALBERT E, INDEPENDENCE
 BAIR MD,GLENN O, TOPEKA
 BAKEBERG,KATHY D, KANSAS CITY
 BAKER MD,HENRY K, CHANUTE
 BAKER MD,PHILLIP L, TOPEKA
 BAKER MD,RAY D, TOPEKA
 BAKER MD,RICHARD B, MANHATTAN
 BAKER MD,WILLIAM STEVEN, SHAWNEE MISSION
 BAKER,JAMES R, SHAWNEE MISSION
 BAKER,MICHAEL P, KANSAS CITY
 BALANOFF MD,ARNOLD Z, SHAWNEE MISSION
 BALDWIN MD,THOMAS F, KANSAS CITY
 BALL MD,RALPH G, MANHATTAN
 BAMMEL MD,BRUCE, WICHITA
 BANKS MD,ROBERT E, PAOLA
 BANKS,DONALD E, KANSAS CITY
 BANSAL MD,ROOPA O, SHAWNEE MISSION
 BANSAL MD,SATISH C, SHAWNEE MISSION
 BAPTIST MD,JEREMY E, SHAWNEE MISSION
 BARABAN MD,MARC R, TOPEKA
 BARBA JR MD,ANTONIO P, WICHITA
 BARBA MD,ESTRELLA G, WICHITA
 BARBER MD,JAMES L, AUGUSTA
 BARBERA MD,PORTER E, INDEPENDENCE
 BARCELO MD,JEANNE A, WICHITA
 BARE II MD,CHARLES E, SHAWNEE MISSION
 BARE,JANE E, KANSAS CITY
 BARELLI MD,PAT A, KANSAS CITY,MO
 BARKER MD,BENJAMIN W, WICHITA
 BARKER MD,ELIZABETH B, SHAWNEE MISSION
 BARKER MD,JAMES BERTON, SHAWNEE MISSION
 BARKER MD,PATRICK N, PRATT
 BARKER MD,PATSY, WICHITA
 BARKER MD,STANTON L, HUTCHINSON
 BARKER MD,STEVEN E, MINNEAPOLIS
 BARKER,MONTY R, SHAWNEE MISSION
 BARLOW MD,JOHN M, MANHATTAN
 BARNES MD,MARIAN, LANCASTER,CA
 BARNETT JR MD,THOMAS E, SHAWNEE MISSION
 BARNETT MD,ARNOLD M, WICHITA
 BARNETT MD,JAMES A, EMPORIA
 BARNETT MD,ROBERT E, TOPEKA
 BARNHART MD,RONALD J, SHAWNEE MISSION
 BARNES,EDWARD L, KANSAS CITY
 BARR MD,RICHARD N, SHAWNEE MISSION
 BARR,ROBIN R, SHAWNEE MISSION
 BARRETT MD,BRADLEY H, NEODESHA
 BARRICK MD,BRUCE, SHAWNEE MISSION
 BARRY MD,DAVID R, LEAVENWORTH
 BARTAL MD,ELY, WICHITA
 BARTLETT MD,WAYNE C, WICHITA
 BASCOM MD,GEORGE S, MANHATTAN
 BASER MD,ALI N, APO,NY
 BASHAM MD,JAMES J, FORT SCOTT
 BASHAM,BRIAN E, WICHITA
 BASINGER,BRADLEY B, WICHITA
 BASS II MD,ORAL E, WICHITA
 BASS JR MD,LEWIS N, KANSAS CITY
 BASSELL MD,G M, WICHITA
 BASSETT MD,PAUL M, TOPEKA
 BATES MD,MICHAEL D, WICHITA
 BATES MD,MICHAEL N, NEWTON
 BATNITZKY MD,SOLOMON, KANSAS CITY
 BATTISTE MD,CYNTHIA, WICHITA
 BATTY MD,LARRY H, SHAWNEE MISSION
 BAUER MD,LAKE W, SHAWNEE MISSION
 BAUER MD,MARTIN L, SHAWNEE MISSION
 BAUER MD,THOMAS A, HUTCHINSON
 BAUER,JOSEPH G, SHAWNEE MISSION
 BAUER,LAIRD A, KANSAS CITY
 BAUMAN MD,M LEON, WICHITA
 BAUMANN MD,PAUL A, WICHITA
 BAXTER MD,W REESE, SALINA
 BAYLES MD,HUGH G, FREDONIA
 BEACH MD,RICHARD R, TOPEKA
 BEACH,ROBERT L, STRATFORD,CT
 BEAHM MD,ANOL W, GREAT BEND
 BEAHM MD,DONALD E, GREAT BEND
 BEAL MD,RAYMOND J, FREDONIA
 BEALE MD,DAVID A, TOPEKA
 BEAMER MD,LARRY R, WICHITA
 BEARCE,SHARON K, WICHITA
 BEBAK MD,DONALD M, WICHITA
 BEBER MD, JORGE H., WICHITA
 BECK JR,CALVIN E, KANSAS CITY,MO
 BECK MD,CHARLES W, WICHITA
 BECK MD,JOSEPH D, TOPEKA
 BECK MD,WILLIAM R, KANSAS CITY
 BECKER MD,KARL E, WICHITA
 BECKER MD,LESLIE E, KANSAS CITY
 BECKER MD,NANCY J, KANSAS CITY
 BECKER,BRYAN N, SHAWNEE MISSION
 BEDFORD MD,D R, TOPEKA
 BEEBE MD,EDMER, OLATHE
 BEECH MD,RANDALL R, ANDOVER
 BEELMAN MD,FLOYD C, TOPEKA
 BEEZLEY MD,MICHAEL J, SHAWNEE MISSION
 BEGGS MD,DAVID F, GARDEN CITY
 BEILMAN,GREG J, WICHITA
 BEJAR MD,JOSE M, MIAMI,FL
 BELDEN,MARY J, SHAWNEE MISSION
 BELL MD,DELORIS W, SHAWNEE MISSION
 BELL MD,MARK G, SALINA
 BELL,GREGORY A, KANSAS CITY
 BELLER MD,WILLIS L, TOPEKA
 BELLOW-SBLAKELY MD,DAVID S, NEWTON
 BELOT JR MD,MONTI L, LAWRENCE
 BELT MD,ROBERT J, SHAWNEE MISSION
 BELZ,MICHAEL K, SHAWNEE MISSION
 BELZER MD,EDWARD G, SHAWNEE MISSION
 BENA MD,JAMES, PITTSBURG
 BENAGE MD,JOHN F, FORT SCOTT
 BENNETT EXEC SE ,ALLIENE, SHAWNEE MISSION
 BENNETT,S H, KANSAS CITY,MO
 BENNING,TIMOTHY C, WICHITA
 BENSON MD,KIRK T, KANSAS CITY
 BENSON,DAVID R, DALTON,MA
 BERGH MD,JAMES R, WICHITA
 BERGIN MD,JAMES J, KANSAS CITY
 BERKEY MD,VERNON A, PITTSBURG
 BERKLEY MD,DON H, ABILENE
 BERKLEY MD,NORMAN W, SENECA
 BERNHARDT MD,MARK, WICHITA
 BERRIDGE,DEBRA L, KANSAS CITY
 BETHEL MD,CHANDLER S, WICHITA
 BETTIN,BRYCE D, KANSAS CITY
 BETTY,JANE M, KANSAS CITY
 BEUGELSDIJK MD,HENRY PETER, HALSTEAD
 BHARATI MD,RALPH, WICHITA
 BHARGAVA MD,ASHOK KUMAR, LA CROSSE
 BHARGAVA MD,SHOBHANA, LA CROSSE
 BIBERSTEIN,GREG A, WICHITA
 BICHLMEIER MD,FRANKLIN G, KANSAS CITY
 BIEGERT MD,DOUGLAS, WICHITA
 BIERLEIN MD,KENNETH J, PITTSBURG
 BIERMANN MD,HENRY J, WICHITA
 BIERMANN MD,WILLIAM J, WICHITA
 BIGLER MD,F CALVIN, GARDEN CITY
 BIGONGIARI MD,LAWRENCE R, WICHITA
 BIKALES MD,VICTOR WILLIAM, SHAWNEE MISSION
 BILLINGS MD,THOMAS, MCPHERSON
 BILLINGSLEY JR MD,JOHN A, OSAWATOMIE
 BILLINGSLEY MD,THAD H, SHAWNEE MISSION
 BINGAMAN MD,ROBERT W, WICHITA
 BINYON MD,KERNIE W, WICHITA
 BISHOP MD,FRANCIS E, SHAWNEE MISSION
 BISHOP MD,HENRY R, SHAWNEE MISSION
 BISHOP MD,RODNEY LEE, LAWRENCE
 BLACK MD,BRADFORD T, KANSAS CITY
 BLACK MD,CYRIL V, PRATT
 BLACK,DAVID L, KANSAS CITY
 BLACKBURN MD,ROBERT W, COUNCIL GROVE
 BLACKBURN,TIMOTHY L, TOPEKA
 BLACKMAN MD,JACQUES D, WICHITA
 BLAKE MD,HENRY S, TOPEKA
 BLAKELEY,SHARON L, OTTAWA
 BLAKELY,KENT W, WICHITA
 BLANK MD,JOHN N, HUTCHINSON
 BLAYLOCK MD,HOYT C, WICHITA
 BLETZ MD,DONALD B, SHAWNEE MISSION
 BLIM MD,R DON, KANSAS CITY,MO
 BLOCH MD,RALPH N, LIBERAL
 BLOCK MD,JEROME E, COFFEYVILLE
 BLOMQUIST,GLENDA L H, KANSAS CITY
 BLOOM MD,BARRY THEIL, WICHITA
 BLOOM MD,L THEIL, KINGMAN
 BLOOM MD,RODNEY LAMONT, WICHITA
 BLOXHAM MD,THOMAS J, WICHITA
 BLUM D.O.,MICHAEL A, OLATHE
 BLUME, GREGORY M, WICHITA
 BOCK,PETER A, MULVANE
 BOEHM MD,DOUGLAS K, WICHITA
 BOEHM MD,HINDY M, WICHITA
 BOESE MD,KENNETH M, MANHATTAN
 BOGNER MD,PAUL F, NEWTON
 BOGNER,KENT A, KANSAS CITY
 BOLES MD,J MICHAEL, SHAWNEE MISSION
 BOLES MD,R DALE, DODGE CITY
 BOLING,JAMES M, SHAWNEE MISSION
 BOLINGER MD,ROBERT E, KANSAS CITY
 BOLLIER MD,RENE P, HOUSTON,TX
 BOLLMAN MD,CHARLES S, JUNCTION CITY
 HOLT MD,MICHAEL, NEWTON
 HOLTON,MARK E, WICHITA
 BOND MD,ROGER C, WICHITA
 BONEBRAKE MD,C RICHARD, TOPEKA
 BOOTON MD,DEBBIE S, WICHITA
 BOREL MD,DAVID, TOPEKA
 BORGENDALE MD,LLEWELLYN V, WAMEGO
 BORRA MD,MARIO J, HUTCHINSON

*Probationary members.

BORRA,HENRY M, KANSAS CITY
 BOS MD,NORMAN C, HUTCHINSON
 BOSILEVAC MD,FRED N, KANSAS CITY
 BOSILJEVAC JR MD,JOSEPH E, EMPORIA
 BOSSE MD,FRANK K, ATCHISON
 BOSSEMEYER II MD,CHARLES H, SALINA
 BOTTERON,GREGORY W, KANSAS CITY,MO
 BOTTERON,KELLY N, KANSAS CITY,MO
 BOUDA MD,DAVID W, HUTCHINSON
 BOUDREAU MD,VELTIN J, HALSTEAD
 BOWEN JR MD,HARRY J, TOPEKA
 BOWEN MD,CLOVIS W, TOPEKA
 BOWEN MD,JUDITH M, TOPEKA
 BOXBERGER MD,GREGORY R, WICHITA
 BOYD MD,SPENCER H, TOPEKA
 BOYD MD,Z REX, WICHITA
 BOYD,HAROLD D, KANSAS CITY
 BOYDEN MD,MARY S, LAWRENCE
 BOYER MD,ROBERT E, KINGMAN
 BOYLE MD,HUGH H, WICHITA
 BRACKETT JR MD,CHARLES E, KANSAS CITY
 BRADA MD,DONALD ROBERT, HUTCHINSON
 BRADEN MD,BILL L, WAMEGO
 BRADLEY MD,FENWICK P, LIBERAL
 BRADLEY MD,H RUSSELL, EMPORIA
 BRADLEY MD,J RODERICK, GREENSBURG
 BRADLEY MD,JOHN G, WICHITA
 BRAHMAN MD,HERBERT D, TOPEKA
 BRAKE MD,DAVID, WICHITA
 BRANDSTED MD,ERNEST C, MCPHERSON
 BRANDT,MERRILEE R, KANSAS CITY
 BRANIECKI MD,MARLYLEE A, KANSAS CITY
 BRANSON MD,VERNON L, LAWRENCE
 BRAUN III MD,WILLIAM T, WICHITA
 BRAUN MD,EDWARD W, FORT SCOTT
 BRAUN MD,KENNETH, WICHITA
 BRAUN MD,ROBERT W, TOPEKA
 BRAUN MD,THOMAS G, WICHITA
 BRAUN MD,WILLIAM T, PORT ORANGE,FL
 BRAUN,STEVEN D, KANSAS CITY
 BRAVERMAN MD,DAVID ELLIOTT, SHAWNEE MISSION
 BRAY MD,AVIS PAGE, CONCORDIA
 BRECKBILL MD,DAVID L, WICHITA
 BRENNER MD,BRIAN C, WICHITA
 BRENT,CHRISTOPHER R, KANSAS CITY
 BRETHOUR MD,LESLIE J, JUNCTION CITY
 BREWER MD,MARSHALL A, ULYSSES
 BRIAN MD,ROBERT M, EL DORADO
 BRIDGE MD,ROBERT S, KANSAS CITY
 BRIDGENS MD,JAMES G, KANSAS CITY,MO
 BRIDWELL MD,RUSSELL E, TOPEKA
 BRILLHART MD,MAXINE T, KANSAS CITY
 BRINKMAN, MARK F, KANSAS CITY
 BRINTON MD,E HOLMES, WICHITA
 BRINTON MD,EDWARD S, WICHITA
 BROCKHOUSE MD,JOHN P, EMPORIA
 BROOKER MD,ROBERT M, SANTA BARBARA,CA
 BROOKS MD,CHARLES L, KANSAS CITY
 BROOKS MD,WILLIAM HENRY, SHAWNEE MISSION
 BROOKS,DOUGLAS G, SHAWNEE MISSION
 BROSIUS MD,FRANK C, WICHITA
 BROWN MD,ALEX L, CLEARWATER,FL
 BROWN MD,C EVERETT, STAFFORD
 BROWN MD,DAVID J, WICHITA
 BROWN MD,FRED E, ST MARYS
 BROWN MD,MICHAEL P, WICHITA
 BROWN MD,ROBERT L, WICHITA
 BROWN MD,ROBERT O, AUBURN,AL
 BROWN MD,ROBERT WAYNE, SALINA
 BROWN MD,RONALD C, WICHITA
 BROWN MD,RONALD L, WICHITA
 BROWN MD,VAL J, WICHITA
 BROWN MD,VAL J JR., WICHITA
 BROWN MD,WILLIAM R, SHAWNEE MISSION
 BROWN-SANDERS MD,CAROLINE, LEES SUMMIT,MO
 BROWN,JEFFERY C, WICHITA
 BROWN,LORAIN L, WICHITA
 BROWN,MICHELLE R, WICHITA
 BROWN,ROBERT L, VAN NUYS,CA
 BROWN,SPENCER A, KANSAS CITY
 BROWNING MD,JIMMIE L, CLAY CENTER
 BROWNING MD,WILLIAM H, WICHITA
 BROXTERMAN MD,STEVEN JOSEPH, SHAWNEE MISSION
 BROZEK MD,JEFFREY E, GREAT BEND
 BRUEGGER,DANIEL E, SHAWNEE MISSION
 BRUMMETT MD,RICHARD R, WICHITA
 BRUNER JR MD,KENNETH W, TOPEKA
 BRUNFELDT MD,JOAN KRAUS, LAWRENCE
 BRUNGARDT MD,BERNARD A, SALINA
 BRUNGARDT MD,GERARD S, HORTON
 BRUNING MD,DANIEL LEE, SHAWNEE MISSION
 BRUNING MD,ROGER MARION, SHAWNEE MISSION
 BRUNO MD,JAMES W, GARDEN CITY
 BRYAN MD,EMERY C, ERIE
 BRYANT MD,R KEVIN, CLAY CENTER
 BUBB MD,STEPHEN K, SHAWNEE MISSION
 BUBECK MD,RALPH W, WICHITA
 BUCK JR MD,BEN H, WICHITA
 BUCK JR MD,HENRY W, LAWRENCE
 BUCK JR,WILLIAM D, SHAWNEE MISSION
 BUCKINGHAM,ULISA D, KANSAS CITY
 BUCKMAN MD,MARTIN SPALDING, SHAWNEE MISSION
 BUDETTI MD,JOSEPH A, N MIAMI BEACH,FL
 BUESING MD,OLIVER R, LEAVENWORTH
 BUHR,BRUCE R, SHAWNEE MISSION
 BULA MD,RALPH E, HAYS
 BULLER MD,DAVID L, WICHITA
 BUNKER JR MD,HERBERT L, JUNCTION CITY

*Probationary members.

BURGER MD,J DALE, HUTCHINSON
 BURGER MD,PAUL B, SHAWNEE MISSION
 BURGER MD,WILLIAM E, BASEHOR
 BURGESSON MD,FRANK G, EMPORIA
 BURGESS MD,ARTHUR P, OSWEGO
 BURKE MD,JAMES J, FORT SCOTT
 BURKE MD,JOSEPH V, ATCHISON
 BURKE MD,MICHAEL A, KANSAS CITY
 BURKE,MICHAEL J, WICHITA
 BURKET JR MD,GEORGE E, KINGMAN
 BURKMAN MD,REUBEN J, CHANUTE
 BURNETT MD,A DEAN, HALSTEAD
 BURNEY II MD,WILLIAM W, WICHITA
 BURNEY MD,WILLIAM W, WICHITA
 BURPEE MD,JAMES P, WICHITA
 BUSER MD,WILLIAM D, SHAWNEE MISSION
 BUSTOS MD,JONAS G, HERINGTON
 BUTCHER MD,THOMAS P, EMPORIA
 BUTH MD,DENNIS K, WICHITA
 BUTIN MD,J WALKER, WICHITA
 BUTLER MD,DORIS C, WICHITA
 BYERS MD,JONELL, SALINA
 BYERS MD,MARTHA S, HUTCHINSON
 BYRNE MD,JAMES PERRY, WICHITA

C

CABALLERO MD,RENATO M, WICHITA
 CABRERA MD,ALBERTO, MCPHERSON
 CACHIA MD,RICHARD M, TOPEKA
 CAEDO MD,CARMELITA D, LIBERAL
 CALBECK MD,JOHN, GARDEN CITY
 CALDERON MD,JAIME, KANSAS CITY
 CALIENDO JR MD,DANIEL J, WICHITA
 CALKINS MD,JOHN W, KANSAS CITY
 CALKINS MD,LARRY L, SHAWNEE MISSION
 CAMERON MD,WILLIAM J, KANSAS CITY
 CAMERON,JULIE P, KANSAS CITY
 CAMPBELL MD,EDWARD G, EMPORIA
 CAMPBELL MD,GARLAND L, ARKANSAS CITY
 CAMPBELL MD,LINDA HINSCH, SHAWNEE MISSION
 CAMPBELL MD,WILLIAM H, COFFEYVILLE
 CAMPION MD,MARY K, WICHITA
 CANDELA, M.D., ANDRES, WICHITA
 CANNADAY MD,JOHN J, WICHITA
 CANNATA MD,GENE, GREENSBURG
 CANNON MD,DONALD C, POCAHONTAS,AK
 CANNON MD,MICHAEL W, WICHITA
 CANTWELL MD,MICHAEL L, COFFEYVILLE
 CAPPER MD,STANLEY L, WICHITA
 CAREY MD,LARRY J, PARSONS
 CARLSON MD,EARL V, HAYS
 CARLSON MD,MARK V, WICHITA
 CARLSON MD,TERRY S, WICHITA
 CARNEY,LISA ANN, KANSAS CITY
 CARPENTER MD,PAUL R, KANSAS CITY
 CARPER MD,IVAN H, NEWTON
 CARPER MD,OWEN E, NEWTON
 CARREAU MD,ERNEST P, CEDAREIDGE,CO
 CARRIAGA,MARISA T, KANSAS CITY,MO
 CARRO MD,F AURELIO, WINFIELD
 CARRO,TONY L, WINFIELD
 CARTER MD,MACK A, FALL RIVER
 CARTY,RUSSEL W, SHAWNEE MISSION
 CASEY MD,JAMES, HUTCHINSON
 CASHMAN JR MD,MAURICE R, TOPEKA
 CASIDY,JERRY A, SHAWNEE MISSION
 CASTEEL MD,CHARLES K, SHAWNEE MISSION
 CASTEEN,JOHN A, KANSAS CITY
 CASTELLANI MD,SAM, WICHITA
 CASTERLINE,JOHN B, WICHITA
 CATHCART-RAKE MD,WILLIAM P, SALINA
 CATHEY MD,ROBERT H, MANHATTAN
 CATO,TERI A, WICHITA
 CATTANEO MD,ERNEST A, SHAWNEE MISSION
 CAUBLE MD,WILBUR G, WICHITA
 CAUGHLIN MD,GERALD MICHAEL, WICHITA
 CAVANAUGH MD,CLAIR J, GREAT BEND
 CAVANAUGH,TIMOTHY B, SHAWNEE MISSION
 CAWLEY MD,LEO P, WICHITA
 CECIL III MD,JOHN, HAYS
 CEDERLIND MD,CRANSTON JAY, SHAWNEE MISSION
 CENAC MD,MARK T, LEAVENWORTH
 CERVENY MD,CARLA J, KANSAS CITY
 CHAFFEE MD,DEAN C, ABILENE
 CHALABI,PHILLIP M, SHAWNEE MISSION
 CHALIAN MD,ALEXANDER R, KANSAS CITY
 CHAMBERLIN JR MD,CECIL R, TOPEKA
 CHANEY MD,ERNIE J, WICHITA
 CHANG MD,C H JOSEPH, KANSAS CITY
 CHANG MD,FREDERIC C, WICHITA
 CHAPMAN MD,JAMES H, KANSAS CITY,MO
 CHARD MD,FREDERICK H, WICHITA
 CHAVEZ MD,STEVE, WICHITA
 CHEN MD,CHU-CHI, TOPEKA
 CHEN MD,TAK-MING, TOPEKA
 CHENG,MEI Y, WICHITA
 CHERAY,JAMES A, SHAWNEE MISSION
 CHERNOFF MD,MARY A, KANSAS CITY
 CHERRY JR MD,ARTHUR C, TOPEKA
 CHERVEN MD,PHILIP L, HUTCHINSON
 CHI MD,IL-SUNG, WICHITA
 CHIN MD,HONG W, SHAWNEE MISSION
 CHIN MD,TOM D, KANSAS CITY
 CHIN,CRAIGHTON, KANSAS CITY
 CHO MD,CHENG T, KANSAS CITY
 CHO MD,SECHIN, WICHITA
 CHOPRA MD,RAMAN, WICHITA
 CHOTIMONGKOL MD,ANUPONG, DODGE CITY

CHOW MD,STANLEY Y, FORT SCOTT
 CHOY MD,JAMES K L, SUN CITY,AZ
 CHRISTENSEN MD,MARION D, KIOWA
 CHRISTENSEN MD,SHANE R, KANSAS CITY,MO
 CHRISTMAN JR MD,CARL, WICHITA
 CHRONISTER MD,BERT, NEODESHA
 CHUNG MD,JOHN J, SHARON SPRINGS
 CHUNG,CLARA K, KANSAS CITY
 CISKEY MD,WILLIAM J, EUREKA
 CLAASSEN MD,MILTON A, NEWTON
 CLAASSEN MD,SAMUEL D, MCPHERSON
 CLAIBORNE MD,RICHARD A, WICHITA
 CLARK MD,COURTNEY, WICHITA
 CLARK MD,CRAIG N, TOPEKA
 CLARK MD,DAVID H, SALINA
 CLARK MD,LAURENCE A, WAMEGO
 CLARK MD,RAY A, LAKE CHAS,LA
 CLARK,CHUCK, KANSAS CITY,MO
 CLARK,GORDON B, KANSAS CITY
 CLARK,PERRY L, KANSAS CITY
 CLAWSON MD,D KAY, KANSAS CITY
 CLAY,MICHAEL J, WICHITA
 CLENDENIN MD,ROBERT KEELE, SHAWNEE MISSION
 CLIFTON MD,H DAVID, WICHITA
 CLINE MD,BYRON W, WICHITA
 COADY,MARY ANN, KANSAS CITY
 COALE MD,LLOYD H, KANSAS CITY
 COATS MD,BARBARA S, WICHITA
 COBB MD,LESLIE H, MULVANE
 COBB,JEANNINE M, WICHITA
 COCHRAN III DO,CASEY G, WICHITA
 COCHRAN MD,KEVIN S, KANSAS CITY,MO
 COCHRAN MD,PAUL W, TOPEKA
 COE MD,RICHARD O, SHAWNEE MISSION
 COFFEY MD,ROY B, SALINA
 COHEN MD,JUSTIN THOMAS, WICHITA
 COHEN MD,LOUIS, TOPEKA
 COHEN MD,ROBERT A, SHAWNEE MISSION
 COHLMA MD,JERRY B, WICHITA
 COHN MD,ELLIOT J, KANSAS CITY
 COHN MD,STEVEN G, KANSAS CITY
 COHN,L ELIZABETH, KANSAS CITY
 COKELEY MD,JOHN M, TOPEKA
 COKER JR MD,GRADY N, HUTCHINSON
 COKER MD,W LAURENCE, TOPEKA
 COLE MD,WARD M, WELLINGTON
 COLEMAN MD,GARY, ABILENE
 COLEMAN MD,ROBERT L, SHAWNEE MISSION
 COLEMAN MD,THOMAS J, WICHITA
 COLIP MD,F MERLYNN, NORTON
 COLLIER MD,HAROLD W, WICHITA
 COLLIER MD,WILLIAM J, MCPHERSON
 COLLINS MD,DEAN T, TOPEKA
 COLLINS MD,EDWARD JOSEPH, TOPEKA
 COLLINS MD,SHARON A, GARDEN CITY
 COLLINS,DAVID E, KANSAS CITY
 COLLINS,JEFFREY S, KANSAS CITY,MO
 COLYER,JEFFREY W, WASHINGTON
 COMBS MD,PETER S, LEAVENWORTH
 CONANT MD,MERRILL, DODGE CITY
 CONANT,FERRILL R, WICHITA
 CONARD MD,CLAIR C, DODGE CITY
 CONCANNON,CRAIG A, BELOIT
 CONCEPCION JR MD,EUGENIO S, WICHITA
 CONGRESS MD,HOWARD J, KANSAS CITY,MO
 CONNELLY MD,MAURICE R, LOUISVILLE,KY
 CONNER MD,BRIAN, SALINA
 CONNOR MD,CAROL S, KANSAS CITY
 CONRARDY MD,PETER A, WICHITA
 CONROY MD,ROBERT W, TOPEKA
 COOK D O, RANDY A, HAYS
 COOK EXEC DIR ,BYRON, TOPEKA
 COOK MD,ANDREW S, WICHITA
 COOK MD,DONALD RAY, WICHITA
 COOK MD,G EDWARD, WICHITA
 COOK,KAROLYN M, WICHITA
 COOK,THEODORE R, WICHITA
 COOLEY MD,DAVID A, SHAWNEE MISSION
 COOLEY MD,DENNIS M, TOPEKA
 COOMER MD,TYLER E, PITTSBURG
 COONFIELD MD,JAMES W, KANSAS CITY
 COONROD,SCOTT A, SHAWNEE MISSION
 COOPER MD,ARTHUR E, NORTON
 COOPER MD,JACK R, SHAWNEE MISSION
 COOPER MD,JAMES L, SALINA
 COOPER MD,LEO F, DREXEL,MO
 COOPER MD,M KENT, WICHITA
 COOPER,CATHY N, PLATT CITY,MO
 COPELAND MD,JACK L, PITTSBURG
 COPENING MD,TELL B, IOIA
 COPPLE JR MD,HAL E, TOPEKA
 CORBIN MD,MURRAY D, SHAWNEE MISSION
 CORDER MD,ROBERT L, ST JOSEPH,MO
 CORNELL MD,EARL G, CONCORDIA
 COSSETTE MD,JERROLD E, SALINA
 COSSMAN MD,F PRICE, WICHITA
 COTTON MD,ROBERT T, TOPEKA
 COUGHENOUR MD,MARK E, SHAWNEE MISSION
 COULTER D.O. MD,THAYNE A, CLYDE
 COULTER MD,HENRY F, SHAWNEE MISSION
 COULTER MD,THOMAS B, SHAWNEE MISSION
 COWLES MD,GORDON T, WICHITA
 COWLEY JR MD,BENJAMIN D, KANSAS CITY
 COX III MD,IRA L, KANSAS CITY
 COX JR MD,IRA, SHAWNEE MISSION
 COX MD,GLENDON G, KANSAS CITY
 COX,MARCIA M, WICHITA
 COX,MICHAEL R, KANSAS CITY
 COX,REAGAN M, KANSAS CITY

COZAD,SCOTT C, LIBERTY,MO
CRAIG MD,CHARLES C, NEWTON
CRAIG MD,THOMAS A, JUNCTION CITY
CRAM JR MD,OLE R, LARNED
CRAM MD,ERNEST R, ST FRANCIS
CRAMER MD,GUY W, PARSONS
CRAMPTON,KARME L, KANSAS CITY
CRANE MD,CHARLES H, MANHATTAN
CRANE MD,DAVID D, WICHITA
CRARY MD,JOHN E, TOPEKA
CRESWELL MD,VALERIE A, WICHITA
CRIDER MD,SUSAN L, TOPEKA
CRIE MD,JOHN S, SHAWNEE MISSION
CROCKETT MD,CHARLES A, KANSAS CITY
CROWNIN MD,DONALD J, WICHITA
CROUCH MD,STEVEN W, TOPEKA
CROUCH MD,WILLIAM H, TOPEKA
CROW MD,ERNEST W, WICHITA
CROWLEY MD,EDWARD X, WICHITA
CROWN MD,STANLEY J, NEWTON
CULP MD,LOUIS M, KANSAS CITY
CULTRON MD,FRANK T, SALINA
CULVER MD,WARREN T, LAWRENCE
CUMMINGS MD,RICHARD J, WICHITA
CURTIS MD,JEFFERY L, CHAPEL HILL,NC
CUTLER MD,PAUL R, KANSAS CITY,MO
CZAPANSKY,DESIREE K, WICHITA

D

D'SOUZA MD,BISMARCK C, SALINA
DADKHAH,NADER, KANSAS CITY
DAHL MD,ASHER W, COLBY
DAIZ MD,ANTONIO S, PARSONS
DAKHIL MD,SHAKER R, WICHITA
DALUM MD,PETER JOSEPH, CLAY CENTER
DANBY MD,JOHN H, WICHITA
DANIELS MD,HERBERT A, KANSAS CITY
DANIELS MD,ROBERT M, VALLEY CENTER
DANIELS,PATRICIA W, SHAWNEE MISSION
DANSDILL MD,DAVID J, WICHITA
DARR MD,RICHARD B, KANSAS CITY
DARRAH MD,JOY N, WICHITA
DAUGHETY MD,TED W, TOPEKA
DAVIA MD,JAMES E, SHAWNEE MISSION
DAVIDSON MD,HARRY T, WICHITA
DAVIS MD,CHESTER R, TOPEKA
DAVIS MD,CHRISTOPHER G, KANSAS CITY
DAVIS MD,DAVID H, LARNED
DAVIS MD,DAVID R, EMPORIA
DAVIS MD,PAUL H, WICHITA
DAVIS MD,RICHARD E, KANSAS CITY,MO
DAVIS MD,RONALD B, WICHITA
DAVIS,BRADLEY E, SHAWNEE MISSION
DAVISON MD,JOE D, WICHITA
DAY MD,HOWARD, WICHITA
DAY MD,HUGHES W, SHAWNEE MISSION
DE BAKKER MD,JAN B, WICHITA
DE HART MD,ARTHUR DONIVA, WICHITA
DE SOUZA MD,DERRICK J, LEAVENWORTH
DE WITT,BARBARA L, KANSAS CITY
DEAY,CHARLES J, SHAWNEE MISSION
DECHAIRO MD,THOMAS, WESTMORELAND
DECKER MD,DONALD D, HALSTEAD
DEDON MD,JON F, SHAWNEE MISSION
DEES MD,DANIEL J, ELLSWORTH
DEGNER MD,JAMES C, WICHITA
DEITZ MD,MICHAEL R, SHAWNEE MISSION
DEITZ,RICHARD M, SHAWNEE MISSION
DEJONG MD,DAVID C, WICHITA
DELGADO MD,SERGIO, TOPEKA
DELGADO MD,SERGIO VICTOR, TOPEKA
DELLETT MD,KENNETH B, EL DORADO
DELMORE MD,JAMES E, WICHITA
DELP MD,MAHLON H, SHAWNEE MISSION
DELPHIA MD,ROBERT E, OLATHE
DELOWORTH,MARK G, KANSAS CITY
DEMOSS MD,ELEANOR P, WICHITA
DEMOTT MD,WAYNE R, KANSAS CITY
DENISON MD,TERRY R, SHAWNEE MISSION
DENNING MD,DALE P, WICHITA
DENNIS MD,DAVID T, MCPHERSON
DEPENBUSCH MD,FRANCIS L, HUTCHINSON
DEPEW,CLIFFORD S, WICHITA
DERRINGTON MD,KENNETH L, SHAWNEE MISSION
DESOIGNIE MD,RAFAEL R, TOPEKA
DETAR MD,GEORGE F, IOLA
DETAR NEWBERT,LE ANNE, BONNER SPRINGS
DETURK MD,DWAYNE L, WICHITA
DEVINS MD,GEORGE S, KANSAS CITY,MO
DIALLO MD,GASTON I, KANSAS CITY
DIAZ MD,DOLORES M, HOUSTON,TX
DIAZ MD,SALVADOR F, HOUSTON,TX
DIAZ,MARIA L, KANSAS CITY
DICK JR MD,HENRY J, EMPORIA
DICK MD,WILLIS G, IOLA
DICK,CAMERON R, KANSAS CITY
DICKINSON MD,CHARLES R, COFFEYVILLE
DIEHL MD,ANTONI M, KANSAS CITY,MO
DIENER MD,CLAYTON H, HESSTON
DILL MD,RODNEY, ATWOOD
DILLARD,SANDY R, WICHITA
DILLON MD,STEVEN C, PRATT
DILLON MD,WILLIAM L, PARSONS
DINGES,DAVID L, WICHITA
DIRKSEN MD,HANS C, WICHITA
DIXON MD,RAYMOND W, COFFEYVILLE

DO, SON T, SHAWNEE MISSION
DOAN MD,TRINAH, WICHITA
DOANE,JOHN F, SHAWNEE MISSION
DOBRATZ MD,ROBERT A, BELOIT
DOCKHORN MD,ROBERT J, SHAWNEE MISSION
DOEBLIN MD,P LAURENCE, WICHITA
DOERRY,KAREN E, KANSAS CITY
DOHERTY MD,WILLIAM R, SHAWNEE MISSION
DOLAN JR MD,PHILIP JARVIS, WICHITA
DONATELLE MD,EDWARD P, WICHITA
DONLEY MD,JAMES L, WICHITA
DONNELL MD,JAMES M, WICHITA
DOOLITTLE MD,GARY C, KANSAS CITY
DORNHOFFER,JOHN L, KANSAS CITY
DOUBEK MD,HERBERT D, BELLEVILLE
DOUBEK,DEBBIE L, SHAWNEE MISSION
DOUGHERTY MD,THOMAS M, GARNETT
DOUGHERTY,WILLIAM S, KANSAS CITY
DOUTHIT MD,DOUGLAS DAVID, WICHITA
DOWELL MD,JAMES C, SALINA
DOWNARD,JAMES M, WICHITA
DOWNS MD,NANCY J, SHAWNEE MISSION
DOZIER MD,FRED S, HERINGTON
DRAEMEL MD,H RICHARD, SALINA
DRAKE MD,CYNTHIA K, SHAWNEE MISSION
DRAKE MD,DOUGLAS J, BELOIT
DRAKE MD,RALPH L, WICHITA
DRAZEK MD,GEORGE, WICHITA
DRAZEK MD,JANE K, WICHITA
DREES MD,BETTY M, SHAWNEE MISSION
DREHER MD,HENRY S, SALINA
DREILING MD,ROGER J, SHAWNEE MISSION
DREVETS MD,CURTIS C, WICHITA
DUCKETT II MD,THOMAS G, SHAWNEE MISSION
DUCKETT MD,THOMAS G, HIAWATHA
DUGAN,DAVID L, WICHITA
DUICK MD,GREGORY, WICHITA
DUJOVNE MD,CARLOS A, KANSAS CITY
DULIN MD,JOSE I, KANSAS CITY
DUNAGIN MD,JACK A, TOPEKA
DUNCAN MD,KIRK A, KANSAS CITY
DUNFIELD,JAY A, KANSAS CITY
DUNIVEN MD,PHILIP L, TOPEKA
DUNLAP MD,PATRICK S, FORT SCOTT
DUNLAP MD,RICHARD L, LAWRENCE
DUNN MD,DANIEL R, SCOTT CITY
DUNN MD,MARVIN I, KANSAS CITY
DUNSHEE MD,CARLYLE M, FORT SCOTT
DUNSHEE MD,CHERYL A, FORT SCOTT
DURANO MD,ANTONIO C, WICHITA
DURKEE MD,BRUCE W, SHAWNEE MISSION
DURKEE MD,WILLIAM R, MANHATTAN
DURST JR MD,ROBERT D, TOPEKA
Dwyer,JOHN E, KANSAS CITY
DYCK MD,ERIC LEE, HAYS
DYCK MD,GEORGE, NEWTON
DYER MD,VERNON E, WICHITA
DYER,DAVID S, KANSAS CITY
DYSART MD,JACK C, STERLING

E

EARL DO,JEFFREY J, KANSAS CITY
EASTES MD,GARY DEAN, HALSTEAD
EATON MD,EDWARD L, TOPEKA
EATON MD,GLEN E, SALINA
EATON MD,LESLIE F, SALINA
EBRAHIMI,KAMILLE G, KANSAS CITY
ECK,MARCI J, WICHITA
ECKART MD,DE MERLE E, HUTCHINSON
ECKERT MD,WILLIAM G, WICHITA
EDDY MD,VICTOR M, HAYS
EDMONDS,MARTA J, SHAWNEE MISSION
EDROZO MD,M LUZ LUNA, PARSONS
EDWARDS MD,DAVID J, EMPORIA
EDWARDS MD,MANIS C, WICHITA
EDWARDS,KIMBERLY K, BUCYRUS
EDWARDS,SHELLEY J, SHAWNEE MISSION
EGBERT MD,ANNE MARSH, WICHITA
EGE,DAVID L, KANSAS CITY
EGEA MD,FERNANDO M, KANSAS CITY
EGELHOF MD,RICHARD H, WICHITA
EHLY,CHRISTOPHER J, KANSAS CITY,MO
EICHHORN MD,FRANK D, GARDEN CITY
EISEMANN MD,ALLAN D, KANSAS CITY
EISENHUT,RANDY E, OLATHE
EKENGREN,HUGH I, KANSAS CITY
EL BORNO MD, SAMIR, TOPEKA
ELANGOVAN,SUDHA, WICHITA
ELCOCK,DAVID G, SHAWNEE MISSION
ELDER MD,D MIKEL, TOPEKA
ELLIS MD,BOBBY J, EMPORIA
ELLIS MD,S CHRISTOPHER, OLATHE
ELLIS,LAVELLE A, WICHITA
ELLISON MD,PAUL D, SALINA
EMAMI MD,ABBAS, KANSAS CITY
EMTG,MARK D, SHAWNEE MISSION
EMMOTT MD,DAVID F, SHAWNEE MISSION
EMPSON MD,CHARLES L, INDEPENDENCE
ENDERS MD,WRAY, SHAWNEE MISSION
ENGELKEN MD,SUSAN F, ST MARYS
ENGEN,PHIL L, KANSAS CITY
ENNS MD,EUGENE K, NEWTON
ENNS MD,JAMES H, LAKE HAVASU CTY,AZ
ENNS,STEPHEN J, SHAWNEE MISSION
ENOCH MD,ROLLAND, WICHITA
ENS MD,GERHARD GEORGE, HILLSBORO
ENS MD,PETER D, HILLSBORO
EPLEE MD,JOHN R, ATCHISON

ERDWIEN,BARBARA A, KANSAS CITY
ERICKSON MD,CLARENCE W, PITTSBURG
ERKEN MD,RONALD V, WICHITA
ERNST MD,R L, WICHITA
ERNST MD,TARI MAE, WICHITA
ESCH MD,JOHN G, PITTSBURG
ESRIG D.O. ,HAROLD L, SHAWNEE MISSION
ESTEP MD,THOMAS H, WICHITA
ESTES MD,NORMAN C, KANSAS CITY
ESTRADA MD,EDMUNDO C, LIBERAL
ESTRADA MD,LINA, LIBERAL
ETZENHOUSER III MD,RUSSELL D, SHAWNEE MISSION
EUGENIO MD,HENRY M, CHERRYVALE
EVANS JR MD,WILLIAM E, SHAWNEE MISSION
EVANS MD,CAROL ANN, SHAWNEE MISSION
EVANS MD,FARRIS D, WICHITA
EVANS MD,JOHN F, WICHITA
EVANS MD,RICHARD G, KANSAS CITY
EVANS MD,ROGER WILLIAMS, WICHITA
EVANS MD,WILLIAM R, GREAT BEND
EWING MD,THOMAS D, LARNED
EYSTER MD,ROBERT L, WICHITA

F

FAILING,TRENT L, OLATHE
FAIRCHILD MD,JOHN A, MANHATTAN
FAKHOURY,MARK, KANSAS CITY,MO
FALTER MD,RICHARD T, HUTCHINSON
FANNING MD,JANET L, AUGUSTA
FANNING MD,KYLE W, AUGUSTA
FANSHIER,SHAWNETTE L, KANSAS CITY
FARAG MD,AZMI E, WICHITA
FARHA MD,GEORGE J, WICHITA
FARHA MD,S JIM, WICHITA
FARLEY MD,JAMES A, WICHITA
FARMER III D.O. ,F J, STAFFORD
FAROOKI MD,ZIA O, TOPEKA
FARRIS MD,RONNIE S, EMPORIA
FAST MD,ROBERT E, ATCHISON
FAST MD,W SPENCER, ATCHISON
FAST,GARY A, WICHITA
FEAGAN MD,JERRY, TOPEKA
FEAGINS-ALEXANDER,SHIRLEY J, WICHITA
FEAREY MD,ALAN J, WICHITA
FEIFAREK MD,MICHAEL J, TOPEKA
FEIGHNY MD,ROBERT E, SALINA
FELDMAYER MD,SEELEY T, MEADE
FELTS,ARTHUR D, SHAWNEE MISSION
FENT MD,LEE S, NEWTON
FENTON MD,ROBERT M, GARDEN CITY
FERGUSON DO,ELAINE L, SALINA
FERNANDEZ MD,HECTOR O, HOISINGTON
FERNANDEZ MD,LUIS A, TOPEKA
FERNANDEZ MD,MIGUEL A, TOPEKA
FERNIE MD,ROBERT W, BOULDER,CO
FERREE MD,RICHARD ALLAN, MCPHERSON
FERRELL MD,DONALD P, WICHITA
FERRIS MD,BRUCE G, WICHITA
FEUILLE JR MD,EDMOND G, WICHITA
FIELD MD,RICHARD A, TOPEKA
FIELDS D.O. ,STEPHEN, WICHITA
FIELDS MD,GALEN W, MCPHERSON
FIESER MD,CARL W, GREAT BEND
FILLEY MD,VERNON W, PRATT
FILLMAN MD,ELDON M, TOPEKA
FINK MD,ABRAHAM A, PLANTATION,FL
FINLEY MD,BRENT E, KANSAS CITY
FINLEY MD,DENNIS R, WICHITA
FISCHER MD,REX R, MANHATTAN
FISHER MD,JAMES B, COLORADO SPRINGS,CO
FISHER MD,RAY F, WICHITA
FISHER MD,RONALD M, LAKEWOOD,NJ
FITZGERALD MD,E JAMES, COLBY
FITZGERALD MD,EDWARD J, WICHITA
FITZIG MD,SANFORD, WICHITA
FITZPATRICK,PAMELA S, KANSAS CITY
FLANDERS MD,H ALDEN, EDINBURGH,TX
FLANNER MD,FRANK R, HOISINGTON
FLEER,GERALD K, SHAWNEE MISSION
FLEMING MD,FORNEY W, WICHITA
FLESKE MD,LEONARD T, GREAT BEND
FLOERSCH MD,HUBERT M, KANSAS CITY
FLOWERS JR MD,CLELL B, WICHITA
FLUTER,GEORGE G, KANSAS CITY
FLUTY,STEVEN R, SHAWNEE MISSION
FORD MD,CHARLES R, WICHITA
FORD MD,FRED L, TOPEKA
FORDYCE MD,NORMAN, SHAWNEE MISSION
FORET MD,JOHN D, KANSAS CITY
FORSTER JR MD,LOUIS G, WICHITA
FORTUNE MD,CEDRIC B, OLATHE
FOSTER MD,D BERNARD, TOPEKA
FOSTER MD,FRANCES J, KANSAS CITY
FOWLER MD,ROBERT J, WICHITA
FOWLER MD,WAYNE L, CONCORDIA
FOX MD,DEANNA K, KANSAS CITY
FRANCIS MD,ANTHONY E, SALINA
FRANCIS MD,NORTON L, WICHITA
FRANCISCO MD,CLARENCE L, SHAWNEE MISSION
FRANCISCO MD,DAN A, WICHITA
FRANCISCO MD,EDGARD, HORTON
FRANCISCO MD,LINDA L, WICHITA
FRANCISCO MD,W DAVID, KANSAS CITY
FRANGIE,JOHN P, E LONGMEADOW,MA
FRANK-GEIER,MARY S, SHAWNEE MISSION
FRANKEL MD,SCOTT J, SHAWNEE MISSION
FRANKLIN JR MD,BENJAMIN A, TOPEKA
FRANKLIN,MICHAEL D, KANSAS CITY

*Probationary members.

FRANSEN MD,HERBERT, NEWTON
FRANSEN MD,PAUL H, NEWTON
FRECHETTE,ALAN R, PHOENIX,AZ
FREDERICK MD,M F, HUGOTON
FREDRICKSON MD,DOREN D, KANSAS CITY
FREDRICKSON MD,DUANE E, LINDSBORG
FREEBORN JR MD,WARREN S, CLYDE
FREEMAN MD,F GILES, PRATT
FREEMAN MD,FRED A, MANHATTAN
FREEMAN MD,MALCOLM C, PITTSBURG
FREEMAN MD,RAYMOND S, SALINA
FRENCH MD,JAMES E, WICHITA
FRENCH MD,JEROME E, WICHITA
FRENKEL MD,JACOB K, KANSAS CITY
FRIESEN MD,DALE, LAWRENCE
FRIESEN MD,ORLANDO J, BUHLER
FRIESEN MD,STANLEY R, KANSAS CITY
FRIESEN,SUSAN G, WICHITA
FRITZ MD,GEORGE E, TRAVERSE CITY,MI
FRITZMEIER MD,WILLIAM H, WICHITA
FROMER MD,JOEL, WICHITA
FROMM MD,ARTHUR H, WICHITA
FROST JR,WILLIAM R, AURORA,CO
FROST,ELIZABETH L, WICHITA
FRY MD,LUTHER L, GARDEN CITY
FUGATE MD,CARL L, BELOIT
FULTON MD,JOHN K, WICHITA
FUNK MD,EDWARD D, LAWRENCE

G

GABRIELLI JR,WILLIAM F, KANSAS CITY
GAGE MD,BETSE M, SHAWNEE MISSION
GALICHIA MD,JOSEPH P, WICHITA
GALLEUGH MD,KEITH W, SHAWNEE MISSION
GALVAN MD,ALONSO, WICHITA
GANDHI MD,SHANTIKUMAR K, TOPEKA
GANN MD,E LAMONTE, EMPORIA
GANS MD,FREDERICK A, SALINA
GANZARAIN MD,RAMON C, TOPEKA
GARCIA MD,FRANCISCO, SHAWNEE MISSION
GARCIA MD,GOULD C, EMPORIA
GARCIA MD,GUILLERMO O, DODGE CITY
GARCIA-FERRER,CIRA M, SHAWNEE MISSION
GARD MD,RAYMOND F, WICHITA
GARDINER,ROBERT C, SHAWNEE MISSION
GARDNER MD,JAMES D, MANHATTAN
GARRETT,DALE G, KANSAS CITY
GAST,KRISTIE L, KANSAS CITY
GATENO MD,JOSEPH, GREAT BEND
GATSCHET,TIMOTHY P, SEDGWICK
GAUGHAN MD,MICHAEL J, SHAWNEE MISSION
GAUME MD,JAMES C, PALOS VERDES,CA
GAY MD,JOHN D, TOPEKA
GAYNES,STUART M, KANSAS CITY
GEARY MD,ALICE L, WICHITA
GEHRT MD,EARL B, CHANUTE
GEIER,DAVID L, KANSAS CITY
GEITZ MD,JAMES M, EMPORIA
GENCH MD,RAYMOND L, CARMEL,CA
GENDEL MD,JOSEPH E, TOPEKA
GENILO MD,AMANCIO C, WICHITA
GENILO MD,CELESTE A, WICHITA
GENTRY MD,JAMES H, DENVER,CO
GENTRY MD,KALE C, SHAWNEE MISSION
GEORGE MD,EARL F, WICHITA
GEORGE,PAULA Y, KANSAS CITY
GERBER MD,ALLEN D, WICHITA
GERBER MD,HARRY A, KANSAS CITY
GERJARUSAK MD,PRAPAS, KANSAS CITY
GERNON,CROSBY, KANSAS CITY
GERROND,LINDA L, SHAWNEE MISSION
GERWICK MD,CHARLES L, KANSAS CITY
GESSLER MD,DONALD J, HOUSTON,TX
GETTLER MD,DEAN T, FORT SCOTT
GIBBS MD,EUGENE, COFFEYVILLE
GIERBOLINI MD,JOSE I, TOPEKA
GIESSEL MD,MICHAEL D, TOPEKA
GILBERT II MD,JOHN H, GARDEN CITY
GILBERT MD,J HOWARD, SENECA
GILBERT MD,ROBERTA M, SHAWNEE MISSION
GILHOUSEN MD,FREDERIC M, KANSAS CITY
GILL MD,GEORGE L, LAMPE,MO
GILLEN MD,BILLY A, SHAWNEE MISSION
GILLENWATER,DAVID T, WICHITA
GILLES MD,HELEN M, LAWRENCE
GILLETT,MARK L, SHAWNEE MISSION
GILMARTIN MD,RICHARD C, WICHITA
GIMPLE MD,KENNETH, TOPEKA
GINAVAN MD,DUANE A, EMPORIA
GIRI MD,SHANKER P G, KANSAS CITY
GIVNER MD,DAVID, WICHITA
GLAZZARD MD,CHARLES D, OLATHE
GLEASON MD,JIMMIE A, TOPEKA
GLEASON,JEFFREY J, KANSAS CITY
GLENN MD,JAMES N, EMPORIA
GLENN MD,LYLE G, PROTECTION
GLOVER II,RICHARD M, KANSAS CITY
GLOVER MD,RICHARD M, NEWTON
GNAU MD,FREDRIC B, HALSTEAD
GODFREY MD,JOSEPH L, TOPEKA
GODFREY MD,WILLIAM A, KANSAS CITY,MO
GODWIN MD,PHILLIP A, LAWRENCE
GOERING MD,DONALD D, COLDWATER
GOERING MD,EMIL L, TOPEKA
GOERING MD,MARK, WICHITA
GOERING MD,RANDALL V, WICHITA

GOERTZ MD,LEO R, KANSAS CITY
GOHIL MD,MAHENDRA N, KINGDOM OF SAUDI ARA,
GOINS,BONNIE K, OLATHE
GOLDBERG MD,HERBERT R, WICHITA
GOLDBERG,JOHN M, KANSAS CITY
GOLDSTEIN MD,GERALD L, SHAWNEE MISSION
GOLDSTEIN,ALAN D, NEW YORK,NY
GOLLERKERI MD,MOHAN P, SHAWNEE MISSION
GOLLUB MD,STEVEN B, KANSAS CITY
GOMETZ MD,MODESTO S, PITTSBURG
GOMEZ MD,FRANCISCO, SHAWNEE MISSION
GONZALEZ MD,HIRAM, WICHITA
GOOD MD,JAMES T, FORT SCOTT
GOOD MD,MICHAEL W, CLAY CENTER
GOOD MD,WENDELL LISLE, SHAWNEE MISSION
GOODPASTURE MD,HEWITT C, WICHITA
GOODWIN MD,DONALD W, KANSAS CITY
GOODWIN MD,JOHN A, SHAWNEE MISSION
GOODWIN MD,MARY K, GODDARD
GORDON MD,JAMES R, WICHITA
GOTO MD,HIROSHI, KANSAS CITY
GOYLE MD,KRISHAN K, WICHITA
GOYLE MD,VIMAL, WICHITA
GRABAU MD,GUY M, WICHITA
GRABER MD,CHARLES, NEWTON
GRADY MD,KENNETH L, KANSAS CITY
GRAHAM JR, ARNOLD R, KANSAS CITY
GRAHAM MD,KENNETH L, LEAVENWORTH
GRAHAM MD,THOMAS W, LEAVENWORTH
GRAHAM MD,WALLACE H, KANSAS CITY,MO
GRANGER,NATHAN D, WICHITA
GRANT MD,MICHAEL E, WICHITA
GRANTHAM MD,HERBERT G, FORT SCOTT
GRANTHAM MD,JARED J, KANSAS CITY
GRASHOFF MD,JOYCE A, SHAWNEE MISSION
GRATNY,LINDA L, LEAVENWORTH
GRAUEL MD,CHARLES W, WICHITA
GRAVES MD,JACK W, WICHITA
GRAVES MD,KATHRYN, HUTCHINSON
GRAY MD,C LUCIEN, WICHITA
GRAY MD,DAVID E, TOPEKA
GRAY MD,H TOM, WICHITA
GRAY MD,SCOTT E, LAWRENCE
GRAYB MD,ANTOINE S, TOPEKA
GREENBERG MD,CRAIG P, WICHITA
GREENBERG MD,GEORGE E, DODGE CITY
GREENBERG MD,MARK, TOPEKA
GREENBERGER MD,N J, KANSAS CITY
GREENE MD,HORACE T, TOPEKA
GREENE MD,LAWRENCE S, SHAWNEE MISSION
GREENE MD,RUSSELL E, TOPEKA
GREENWOOD MD,JAMES F, GARDEN CITY
GREENWOOD,JOHN M, KANSAS CITY
GREENWOOD,MELANIE A, WICHITA
GREER MD,JAMES A, WICHITA
GREER MD,RICHARD H, TOPEKA
GRELINGER,BART A, WICHITA
GRENE MD,ROBERT BRUCE, WICHITA
GRIFFING MD,RICHARD B, SALINA
GRIFFITH MD,FRANK H, SALINA
GRIFFITT,WESLEY E, KANSAS CITY
GRILLOT MD,FLOYD B, WICHITA
GRILLOT,MICHAEL B, WICHITA
GRIMALDI MD,GARY A, FORT SCOTT
GRIMALDI MD,KENNETH J, FORT SCOTT
GRIMES MD,I ROSS, LIBERAL
GRIMES MD,JAMES T, LYONS
GRIN MD, TRUDI R, SHAWNEE MISSION
GRISOLIA MD,ANDRES, LEAVENWORTH
GRISWOLD MD,DALE G, NEWTON
GROHS MD,HEINZ K, WICHITA
GROSSMAN MD,HARVEY M, SHAWNEE MISSION
GROSOWALD,DOUGLAS E, KANSAS CITY
GROWNEY MD,JOHN T, ATCHISON
GRUENDEL MD,RICHARD A, KANSAS CITY
GRUENDEL MD,VIRGINIA T, KANSAS CITY
GRUNDMEIER MD,ANNETTE M, SHAWNEE MISSION
GRUSHNYS MD,ARNOLD, WICHITA
GSELL MD,GEORGE F, WICHITA
GUARDIA MD,DAVID K, KANSAS CITY
GUADELLO MD,MARIO J, KANSAS CITY,MO
GUDEMAN,DAVID M, BETHESDA,MD
GUILLAN MD,RAMON A, TOPEKA
GUMUCIO MD,MARIO L, KANSAS CITY
GUNN MD,MARVIN R, SALINA
GUTHRIE MD,RICHARD A, WICHITA
GUTOVITZ MD,ALLEN LOUIS, TOPEKA
GUTTIKONDA MD,PRASAD B, NILES,OH
GUZMAN MD,MANUEL, SALINA
GWINN MD,DOUGLAS R, OLATHE

H

HABASHY MD,SHAWKY N F, WICHITA
HACKER MD,DAVID C, SHAWNEE MISSION
HACKER MD,ELAINE MARY, TOPEKA
HADLEY MD,DELMONT C, OTTAWA
HAPPNER MD,WILLIAM N, EL DORADO
HAGAN MD,C THOMAS, WICHITA
HAGAN MD,FRANCIS J, WICHITA
HAGAN MD,ROBERT C, WICHITA
HAGAN MD,STEPHEN P, WICHITA
HAGGAN MD,MARGARET E, LAWRENCE
HAIGLER MD,JAMES P, HAYS
HALE MD,RALPH, HUTCHINSON
HALL III,MD,THOMAS B, KANSAS CITY
HALL MD,J ROGER, WICHITA
HALL MD,MARK S, WICHITA

HALL MD,WESLEY H, GIRARD
HALL,GARY D, SHAWNEE MISSION
HALLERAN III MD,WILLIAM J, SHAWNEE MISSION
HALLEY MD,M MARTIN, TOPEKA
HALLING MD,L WILLIAM, HAYS
HALLING,AMY C, KANSAS CITY
HALLING,KEVIN C, KANSAS CITY
HALVORSON MD,HOWARD C, OLATHE
HALVORSON,KARI J, KANSAS CITY
HAM,ROBERT E, WICHITA
HAMILL,JOHN M, KANSAS CITY
HAMILTON MD,JAMES J, WAKEENEY
HAMM MD,ORVAL L, PAKISTAN,
HAMMEKE MD,JOHN C, LEAVENWORTH
HAMPEL,JEFF A, KANSAS CITY
HAMPEL,KEVIN G, WICHITA
HAMTIL MD,LAWRENCE W, SHAWNEE MISSION
HAN MD,CHAN S, COFFEYVILLE
HANCOCK MD,ALAN C, KANSAS CITY
HANCOCK MD,DANIEL E, MANHATTAN
HANDS MD,SEBEL V, AMARILLO,TX
HANDSHY MD,STANLEY E, ERIE
HANSEN MD,DANIELS D, HAMET,CA
HANSEN MD,FRANK W, GARDEN CITY
HANSON,ROBERT L, WICHITA
HARA MD,GLENN S, KANSAS CITY
HARBIN MD,GARY LYNN, SALINA
HARD MD,BENJAMIN P, KANSAS CITY,MO
HARDIN MD,CREIGHTON A, KANSAS CITY
HARDY,BRADFORD R, KANSAS CITY
HARMON MD,GARY S, SHAWNEE MISSION
HARMS MD,ALBERT C, SHAWNEE MISSION
HARMS MD,EDWIN M, WICHITA
HARMS MD,WILMER A, HALSTEAD
HARPER,DIANE M, SHAWNEE MISSION
HARRINGTON,ELAINE M, KANSAS CITY
HARRIS JR MD,CLAIB B, GARNETT
HARRIS MD,FRANK H, WICHITA
HARRIS MD,HUBERT L, TOPEKA
HARRIS MD,NORMAN R, SALINA
HARRIS MD,PATRICIA A, TOPEKA
HARRISON MD,HALL E, TOPEKA
HARRISON MD,PAUL BARRY, WICHITA
HART MD,DILLIS L, WICHITA
HART MD,JOHN J, WICHITA
HART MD,KELLY Z, KANSAS CITY
HART MD,LAWRENCE E, ATCHISON
HARTLEY MD,FOUNT K, GAINESVILLE,FL
HARTLEY MD,JAMES M, WICHITA
HARTMAN MD,CHARLES R, KANSAS CITY
HARTMAN MD,GERALD V, SHAWNEE MISSION
HARTMAN MD,ROGER L, NORTON
HARTONG MD,TOBY JOSEPH, SHAWNEE MISSION
HARTONG MD,WILLIAM A, SHAWNEE MISSION
HARTWELL MD,KIMBERLY, WICHITA
HARTWELL MD,RICK L, WICHITA
HARTY,JEAN R, SHAWNEE MISSION
HARVEY MD,JEAN A, DALLAS,TX
HARVEY MD,JOHN E, EMPORIA
HARVEY MD,R CLAY, TOPEKA
HARVEY MD,ROSEMARY B, WICHITA
HARWOOD MD,CLAUDE J, GLASCO
HASKINS MD,ROBERT J, WICHITA
HASSAN MD,RIZWAN U, WICHITA
HASSELLE III MD,JAMES E, LAWRENCE
HASSETT MD,GERARD R, COLBY
HASSLER MD,RANDY D, SALINA
HATESOHL,STANLEY M, CLAY CENTER
HATHAWAY MD,PETER, SHAWNEE MISSION
HATTON MD,DONALD W, LAWRENCE
HATTON MD,LOYD W, SALINA
HATTROP MD,RICHARD J, WICHITA
HAUN MD,RUDY T, MANHATTAN
HAVENHILL II MD,MARSHALL A, EMPORIA
HAWLEY MD,RAYMOND G, WICHITA
HAYES MD,J EDWARD, BOISE,ID
HAYES MD,KRIS A, HIAWATHA
HAYES MD,WILLIAM L, WICHITA
HAYNES MD,DEBORAH G, WICHITA
HAYS MD,THOMAS H, WICHITA
HEADRICK MD,DANIEL E, HUTCHINSON
HEALY MD,PATRICK M, WICHITA
HEASTY MD,ROBERT G, MANHATTAN
HEATON,KEITH M, KANSAS CITY
HEBBAR MD,SATYA N, TOPEKA
HEBDEN,RICHARD J, SHAWNEE MISSION
HEDRICK MD,KENNETH E, HUTCHINSON
HEEB MD,CAMILLE S., TOPEKA
HEIM MD,MARY LEE, KANSAS CITY,MO
HEIT,JOSEPH A, KANSAS CITY,MO
HELENA,WESLEY D, KANSAS CITY
HELLER,DEANNA L, KANSAS CITY,MO
HELLMAN,DAVID W, WICHITA
HELM,DOUGLAS S, SHAWNEE MISSION
HENDERSON II D O,ROBERT C, LIBERAL
HENDERSON MD,DAVID V, GARNETT
HENDERSON,BRYAN K, KANSAS CITY
HENDRICKS MD,K DWIGHT, KANSAS CITY
HENDRICKS MD,RANDALL L, WICHITA
HENDRICKS,WILLIAM J, SHAWNEE MISSION
HENDRICKSON MD,JON R, NEWTON
HENDRICKSON MD,KATHRYN D, NEWTON
HENNEY MD, JANE E, KANSAS CITY
HENNING JR MD,HAROLD J, MANHATTAN
HENNING MD,CALVIN W, OTTAWA
HENNING MD,CHARLES E, WICHITA
HENRY,ROBERT M, SHAWNEE MISSION
HENSON,STEVEN R, HESSTON
HENWOOD MD,JOHN R, WICHITA
HERED MD,JOHN, WICHITA

*Probationary members.

HERL MD,CARY J, SALINA
 HERMRECK MD,ARLO S, KANSAS CITY
 HERRERA MD,JORGE J, TOPEKA
 HERRMAN MD,ADAM L, SALINA
 HERRON,KRISTINE G, SHAWNEE MISSION
 HERSH,CHRISTOPHER K, LAWRENCE
 HERSHBERGER DO. ,GROVER, WICHITA
 HERSHORN MD,SIMON E, WICHITA
 HESSE MD,JAMES F, WICHITA
 HESSER MD,HERBERT H, SHAWNEE MISSION
 HETT MD,EDWARD J, WICHITA
 HETTINGER MD,MICHAEL E, SHAWNEE MISSION
 HICKERT,MAUREEN C, KANSAS CITY,MO
 HICKMAN MD,JAMES STEPHEN, TOPEKA
 HIEBERT MD,DAVID L, LAWRENCE
 HIEBERT MD,JOHN B, TOPEKA
 HIEBERT MD,JOHN M, KANSAS CITY
 HIESTERMAN MD,HERMAN W, QUINTER
 HILDYARD II MD,VICTOR H, COLBY
 HILL MD,JAMES E, ARKANSAS CITY
 HILL MD,LARY MICHAEL, GREAT BEND
 HILL MD,RICHARD H, MEADE
 HILL MD,ROBERT N, TOPEKA
 HILL MD,RODNEY W, SHAWNEE MISSION
 HILST MD,WILBUR D, TOPEKA
 HINKIN MD,DOUGLAS P, MANHATTAN
 HINMAN,TIM S, LONGMONT,CO
 HINSHAW JR MD,CHARLES T, WICHITA
 HINSHAW MD,ALFRED H, WICHITA
 HINSHAW MD,CHARLES T, WICHITA
 HINSHAW MD,EDGAR D, ARKANSAS CITY
 HINSHAW,DARLA J, KANSAS CITY
 HIRATZKA MD,TOMIHARU, HIGH POINT,NC
 HIRSCHBERG MD,J COTTER, TOPEKA
 HITSZCZYNSKYJ MD,ROMAN, TOPEKA
 HITCHCOCK MD,C THOMAS, SHAWNEE MISSION
 HIZON MD,RAMON R, WICHITA
 HO MD,SAMUEL Y, KANSAS CITY,MO
 HOADLEY MD,WILLIAM D, KANSAS CITY
 HOBBS MD,DONALD D, TOPEKA
 HOBSON MD,MILBURN W, SHAWNEE MISSION
 HODES MD,HERBERT C, SHAWNEE MISSION
 HODGES MD,BRUCE E, SHAWNEE MISSION
 HODGES MD,GLENN R, KANSAS CITY
 HODGES MD,MERLE A, SALINA
 HODGSON MD,DAVID K, WASHINGTON
 HODGSON MD,JAMES F, KANSAS CITY
 HODSON MD,HERVEY R, WICHITA
 HOFFER MD,JOHN G, MEDICINE LODGE
 HOFFMAN MD,J PHILIP, LAWRENCE
 HOFFMAN MD,JAMES E, WICHITA
 HOHERZ MD,DAVID G, TOPEKA
 HOHLY MD,EVE K, KANSAS CITY,MO
 HOLCOMB MD,WILLIAM M, LIBERAL
 HOLDCRAFT MD,JACQUELYNE, KANSAS CITY
 HOLDEN JR MD,RAYMOND F, WICHITA
 HOLDEN,JILL K, SHAWNEE MISSION
 HOLDERMAN MD,WALLACE D, HUTCHINSON
 HOLLADAY MD,KENNETH R, EUDORA
 HOLLAND JR MD,DAVID L, WICHITA
 HOLLIS MD,KENNETH W, ARKANSAS CITY
 HOLLOWELL MD,JOSEPH G, KANSAS CITY
 HOLMAN MD,JON B, SALINA
 HOLMES MD,FREDERICK F, KANSAS CITY
 HOLMES MD,GRACE E, KANSAS CITY
 HOLMES MD,JED, WICHITA
 HOLMES MD,JOHN A, KANSAS CITY
 HOLMES MD,ROBERT W, TOPEKA
 HOLSINGER MD,DONALD M, PITTSBURG
 HOLSTRUM,STACY J, BLUE SPRINGS,MO
 HOLT MD,JOHN M, GREAT BEND
 HON,DAVID E, WICHITA
 HOOD MD,ROGER W, SHAWNEE MISSION
 HOOPER MD,WILFORD D, HALSTEAD
 HOPKINS JR MD,B MORRISON, SCOTT CITY
 HOPKINS MD,JAMES P, KANSAS CITY,MO
 HOPKINS MD,LENLY, SHAWNEE MISSION
 HOPKINS MD,WILLIAM O, SHAWNEE MISSION
 HOPPER MD,CHARLES R, EMPORIA
 HOPPOCK,KEVIN C, WICHITA
 HORBELT MD,DOUGLAS V, WICHITA
 HORNBAKER MD,STANLEY D, CARBONDALE
 HORNER,JILLIAN E, KANSAS CITY
 HORSEMAN MD,ROBERT F, SHAWNEE MISSION
 HORTON,GREG A, KANSAS CITY
 HOSTETTER MD,MARCIA M, TOPEKA
 HOUCK MD,CONSTANCE S, KANSAS CITY
 HOURIGAN,RICHARD J, KANSAS CITY
 HOUSE MD,R E, SALINA
 HOUSHOLDER MD,DANIEL FAIR, WICHITA
 HOUSHOLDER MD,MARTHA S, WICHITA
 HOUSTON II MD,LAWRENCE MORLEY, SHAWNEE
 HOUSTON MD,THOMAS P, WICHITA
 HOWARD MD,DONALD O, WICHITA
 HOWELL MD,BARBARA JOYCE, EMPORIA
 HOWELL,STEVEN J, WICHITA
 HOWERTER JR MD,BERNARD E, COFFEYVILLE
 HOYT MD,ARTHUR W, TOPEKA
 HRABIK,BRENT A, SHAWNEE MISSION
 HSU MD,CECILIA C, SHAWNEE MISSION
 HSU MD,CHENG H, TOPEKA
 HSU MD,SHIN-FU, TOPEKA
 HUANG MD,JONSON, TOPEKA
 HUDGINS,MARK A, KANSAS CITY
 HUDSON MD,ROBERT P, OLATHE
 HUEBERT MD,DEAN A, WICHITA
 HUEBNER MD,ROBERT STEPHAN, PITTSBURG

HUERTER MD,DAVID F, PITTSBURG
 HUERTER MD,QUENTIN C, KANSAS CITY
 HUFFORD MD,DAVID W, ANDALE
 HUGHES MD,JOHN D, WICHITA
 HUGHES,STEVEN, KANSAS CITY,MO
 HULTGREN MD,MYRON K, WICHITA
 HUME MD,JOSEPH W, WICHITA
 HUMMER MD,LLOYD M, WICHITA
 HUND MD,LARRY R, WICHITA
 HUND MD,MORRIS A, WICHITA
 HUNKELER MD,JOHN D, KANSAS CITY,MO
 HUNNINGHAKE MD,RONALD, SALINA
 HUNNINGHAKE, DENISE A, KANSAS CITY
 HUNSBERGER D.O. ,TERRY R, GARDEN CITY
 HUNT EXEC SEC ,MARTHA, KANSAS CITY
 HUNT,BRIAN J, KANSAS CITY
 HUNTER JR MD,JAMES S, GREENVALLEY,AZ
 HUNTER MD,KENNETH R, LEBO
 HURLBUT,KEVIN M, KANSAS CITY
 HURWITZ MD,MICHAEL A, HALSTEAD
 HUSEMAN MD,RICHARD ALLAN, NORTH KANS CITY,MO
 HUSTEAD MD,ROBERT F, WICHITA
 HUSTON MD,FRANCIS W, WINCHESTER
 HUSTON MD,JOSEPH W, TOPEKA
 HUTCHINS MD,JOEL R, HOLTON
 HUTCHINSON MD,STEVEN A, WICHITA
 HUTCHISON MD,GLEN C, HAYS
 HUTCHISON MD,JOE R, LEBO
 HUTCHISON MD,MARC K, HAYS
 HUTCHISON MD,MICHAEL C, HAYS
 HUTCHISON,SCOT M, KANSAS CITY
 HUTSEY MD,PAUL J, WICHITA
 HUTTERER,ANGELA J, WICHITA
 HUTTON MD,FREDERICK A, TOPEKA
 HUYCKE MD,EDWARD J, WICHITA
 HYLAND MD,JOSEPH M, TOPEKA
 HYNES MD,HENRY E, WICHITA

IBARRA MD,J LUIS, WICHITA
 IBARRA MD,RICHARD C, KANSAS CITY
 IDBEIS MD,BADR, WICHITA
 ILIFF MD,R DOUGLAS, TOPEKA
 ILIOPOULOS MD,JOHN I, KANSAS CITY
 ILORETA MD,ALFREDO T, TOPEKA
 IMLAY,BRIAN, KANSAS CITY,MO
 IMSEIS MD,MIKHAIL Y, NESS CITY
 INGHAM JR MD,H LAIRD, LAWRENCE
 INGRAM MD,JOHN E, KANSAS CITY
 INNES MD,ROBERT C, SHAWNEE MISSION
 IRBY MD,PRATT, FORT SCOTT
 IRWIN MD,RICHARD L, NEWTON
 ISAAC MD,CHARLES A, NEWTON
 ISAACS MD,JUANITA J, WICHITA
 ISAACSON MD,RICHARD N, TOPEKA
 ISERN MD,HENRY J, KANSAS CITY
 ISSINGHOFF MD,CHAD J, HUTCHINSON
 IWAY MD,BELINO D, ELKHART
 IWAY MD,OLIVIA N, ELKHART

JACKSON JR MD,DELMAS A, SALINA
 JACKSON JR MD,DONALD H, TOPEKA
 JACKSON MD,CHARLES R, WICHITA
 JACKSON MD,ROBERT V, SHAWNEE MISSION
 JACKSON MD,THOMAS M, WICHITA
 JACKSON MD,VICTOR L, ALTAMONT
 JACOB MD,KANNAMPALLY L, EL DORADO
 JACOBS MD,DAVID S, KANSAS CITY
 JACOBS MD,RAE R, KANSAS CITY
 JACOBS,DANIEL H, CORALVILLE,IA
 JACOBSON MD,EUGENE D, KANSAS CITY
 JACOBY II MD,ROBERT E, TOPEKA
 JAEGER,MARY G, WICHITA
 JAHANTAN MD,DARYOUSH, KANSAS CITY
 JALALI,MEHDI, KANSAS CITY
 JAMES MD,DONALD L, WICHITA
 JAMES MD,DONALD R, SHAWNEE MISSION
 JANKOWSKI MD,KAZIMIERZ W, TOPEKA
 JANSEN MD,ERWIN T, TOPEKA
 JANSEN,KATHERINE L, WICHITA
 JARROTT MD,JOHN B, HUTCHINSON
 JASTER MD,PAUL JOSEPH, WICHITA
 JAWADI MD,JAMEELA HUSAIN, WICHITA
 JAYARAM MD,MARANDAPALLI R, KANSAS CITY
 JEHAN MD,SAYED S, WICHITA
 JENAB,JOHN, SHAWNEE MISSION
 JENKINS,DE ANN R, WICHITA
 JENNEY MD,CHARLES B, WICHITA
 JENSEN JR,JOHN T, SHAWNEE MISSION
 JENSEN MD,DARAN L, WICHITA
 JENSEN MD,ROBERT D, TOPEKA
 JENSEN MD,THOMAS M, OLATHE
 JESTER MD,SHELBY L, WICHITA
 JETER MD,JOHN, LAWRENCE
 JETER MD,N TIMOTHY, TOPEKA
 JEWELL MD,WILLIAM R, KANSAS CITY
 JOHNSON MD,BRUCE E, KANSAS CITY
 JOHNSON MD,CAROL ANN, WICHITA
 JOHNSON MD,CAROLYN K, WICHITA
 JOHNSON MD,GEORGE K, WICHITA
 JOHNSON MD,HOWELL D, DODGE CITY
 JOHNSON MD,J RICHARD, MCPHERSON
 JOHNSON MD,JOHN E, SHAWNEE MISSION
 JOHNSON MD,MARGARET J, WICHITA
 JOHNSON MD,PAUL D, LEAVENWORTH

JOHNSON MD,RICHARD L, HUTCHINSON
 JOHNSON MD,TERESA F, WINFIELD
 JOHNSON MD,THOMAS E, WICHITA
 JOHNSON,KEITH A, SHAWNEE MISSION
 JOHNSON,LINDA M, SHAWNEE MISSION
 JOHNSON,ROBERT C, SHAWNEE MISSION
 JONES JR MD,HERMAN H, KANSAS CITY
 JONES MD,BARBARA, KANSAS CITY
 JONES MD,CHARLES E, SHAWNEE MISSION
 JONES MD,EDWARD L, GREAT BEND
 JONES MD,FORREST H, COLUMBUS
 JONES MD,H IVOR, SHAWNEE MISSION
 JONES MD,H PENFIELD, LAWRENCE
 JONES MD,MICHAEL P, ATCHISON
 JONES MD,RODNEY, WICHITA
 JONES MD,WILLIAM T, MANHATTAN
 JONES,DAVID B, SHAWNEE MISSION
 JORDAN,JANET C, KANSAS CITY,MO
 JOSEPH MD,BRIAN W, TOPEKA
 JOSEPH MD,HOWARD F, LAWRENCE
 JOSLIN,CHARLIE G, KANSAS CITY
 JOSS MD,CHARLES S, TOPEKA
 JOST MD,GARY D, WICHITA
 JOYCE MD,G BERNARD, TOPEKA
 JUBELT MD,HILBERT P, MANHATTAN
 JUDILLA JR MD,FRANCISCO, WICHITA
 JUNG,SIMON CY, SHAWNEE MISSION
 JUSTUS MD,WILLIAM J, PLEASANTON

K

KADIAN MD,RAJESH S, SHAWNEE MISSION
 KADISON MD,HERBERT I, WICHITA
 KAHN MD,DAVID M, WICHITA
 KAHRG,GREG, KANSAS CITY,MO
 KALIN,CINDI A, SHAWNEE MISSION
 KALIVAS,LINDA L, SHAWNEE MISSION
 KANE JR MD,WILLIAM M, HAYS
 KARDATZKE MD,E STANLEY, WICHITA
 KARDATZKE MD,JON K, WICHITA
 KARLIN MD,CHARLES A, SHAWNEE MISSION
 KASHA MD,ROBERT L, WICHITA
 KASHYAP MD,BANSHI PRASAD, SHAWNEE MISSION
 KASSEBAUM MD,GLEN E, EL DORADO
 KASSEBAUM MD,KENNETH G, WICHITA
 KASTER,STEVEN D, KANSAS CITY,MO
 KATZ MD,FRED S, SHAWNEE MISSION
 KATZ MD,JEROME B, TOPEKA
 KAUER,CURTIS D, KANSAS CITY
 KAUFMAN MD,EUGENE E, WICHITA
 KAUFMAN MD,LELAND R, WINFIELD
 KAUFMAN MD,WILLARD E, MOUNDRIDGE
 KAVEL MD,KARL K, TOPEKA
 KEARNS MD,NORBERT W, TOPEKA
 KEENE MD,GEORGE H, WICHITA
 KEITH MD, REX B., WICHITA
 KELLER MD,JAMES P, WICHITA
 KELLERMAN MD,RICK, PLAINVILLE
 KELLEY MD,GORDON R, SHAWNEE MISSION
 KELLEY,MARSHALL D, SHAWNEE MISSION
 KELLY MD,A CHRISTINE, HAYS
 KELLY MD,DAN A, TOPEKA
 KELLY MD,ROBERT W, WICHITA
 KELLY,JIM, KANSAS CITY
 KELLY,MICHELE, SHAWNEE MISSION
 KENAGY,ROBERT S, WICHITA
 KENDALL MD,TOM E, WICHITA
 KENDALL,MARK A, WICHITA
 KENDRICK MD,J GILLERAN, WICHITA
 KENNALLY MD,KEVIN P, SABETHA
 KENNEDY MD,GERALD T, WICHITA
 KENNEDY MD,L ELAINE, LAWRENCE
 KENNEDY,CHRISTOPHER S, KANSAS CITY,MO
 KENNING MD,GERALD F, HUTCHINSON
 KEPES MD,JOHN J, KANSAS CITY
 KERLEY MD,SPENCER W, SHAWNEE MISSION
 KERR MD,GERALD F, FORT SCOTT
 KERWIN,MERRITT M, SHAWNEE MISSION
 KETCHERSIDE JR MD,WILLIAM J, KANSAS CITY,MO
 KETCHUM MD,LYNN D, SHAWNEE MISSION
 KETTER,IVAN C, SIOUX CITY,IA
 KEYES MD,MICHAEL J, WICHITA
 KEYS JR MD,ROBERT C, TOPEKA
 KHICHA MD,GYANCHAND J, WICHITA
 KHOURY MD,GEORGE H, WICHITA
 KIFER MD,C JAMES, HAYS
 KIHMD,ALBERT A, CHANUTE
 KIM MD,JONG M, KANSAS CITY
 KIM MD,PAIK N, WICHITA
 KIM MD,YONG W, TOPEKA
 KIM,SUCHA, JUNCTION CITY
 KIMBALL MD,RICHARD R, MANKATO
 KIMBLE MD,JAMES A, WICHITA
 KIMMEL MD,KENNETH K, HALSTEAD
 KIMPLE,KRIS G, WICHITA
 KIMURA,LYLA S, SHAWNEE MISSION
 KIMURA,STEPHEN H, SHAWNEE MISSION
 KINDLING MD,PAUL H, TOPEKA
 KINDRED MD,LYNN H, KANSAS CITY,MO
 KING MD,CHARLES R, KANSAS CITY
 KING MD,WILLIAM T, GREAT BEND
 KING,BRADLEY S, ARKANSAS CITY
 KING,TERESA M, KANSAS CITY
 KINPORTS SR MD,EDWARD B, KANSAS CITY,MO
 KIRCHNER MD,FERNANDO R, KANSAS CITY
 KIRCHNER,LAURA L, KANSAS CITY
 KIRK JR MD,E DAVID, WICHITA
 KIRK MD,THOMAS E, MANHATTAN

*Probationary members.

KIRK,JOHN M, KANSAS CITY
 KIRKEGAARD MD,RODGER S, TOPEKA
 KIRKPATRICK DO JON P, WICHITA
 KIRSCH MD,MARK A, WICHITA
 KIRWAN MD,LAURENCE A, KANSAS CITY,MO
 KISER MD,JOHN L, WICHITA
 KISER MD,WILLARD J, WICHITA
 KISHORE MD,ROY N, PARSONS
 KISHORE MD,SHEELA, PARSONS
 KITCHEN MD,ROBERT R, WICHITA
 KITOWSKI MD,THEODORE L, MARYSVILLE
 KLAFTA MD,LEONARD A, WICHITA
 KLEIN MD,TERRY D, WICHITA
 KLEIN,THOMAS C, KANSAS CITY
 KLEINHOLZ JR MD,EMIL JOHN, TOPEKA
 KLEMM MD,J MARTIN, SHAWNEE MISSION
 KLEMMER MD,HERBERT, TOPEKA
 KLEMDA JR MD,MARTIN B, BELOIT
 KLIEWER MD,VERNON L, NEWTON
 KLINGMAN MD,DIANE D, WICHITA
 KLOBASA MD,CHARLES L, MANHATTAN
 KLOSTERHOFF MD,BRUCE E, HUTCHINSON
 KNAPP MD,LESLIE E, WICHITA
 KNAPP MD,M ROBERT, WICHITA
 KNAPPENBERGER MD,ROY C, MANITOU SPRING,CO
 KNATZ MD,JO M, SHAWNEE MISSION
 KNECHT MD,STEPHEN M, EMPORIA
 KNEIDEL MD,THOMAS W, WICHITA
 KNIGHT MD,LAURA C, WICHITA
 KNIGHT MD,PHILIP J, WICHITA
 KNUDSEN MD, DENNIS, LIBERAL
 KNUTH MD,KENNETH L, INDEPENDENCE
 KODANAZ MD,A AYTEKIN, SHAWNEE MISSION
 KOEHN,DANIEL J, KANSAS CITY
 KOERPER,KARL, KANSAS CITY,MO
 KOHAKE MD,GEORGE A, TOPEKA
 KOKSAL MD,TOM, GARDEN CITY
 KOLSTE MD,REX J, COLBY
 KOONS MD,JESS W, LIBERAL
 KOONTZ MD,JUDITH A, TOPEKA
 KOOSER MD,JUDITH A, TOPEKA
 KOSA MD,ANNAMARIA, ST MARYS
 KOURI MD,SAMMY H, WICHITA
 KOVAC MD,ANTHONY L, KANSAS CITY
 KOVARIK MD,ERNEST D, TOPEKA
 KOWALSKI MD,PETER C, TOPEKA
 KOWALSKI MD,STEPHEN F, TOPEKA
 KOZIKOWSKI MD,BEN M, SHAWNEE MISSION
 KRANTZ MD,KERMIT E, KANSAS CITY
 KRATZ,DONALD P, WICHITA
 KRAUSE MD,MAURICE D, WICHITA
 KRAUSE MD,ROLAND L, AKRON,PA
 KREADY MD,JOHN L, WICHITA
 KREHBIEL MD,MARK A, SALINA
 KRETSINGER DO ,W BROCK, EMPORIA
 KRISHNAN MD,LEELA, SHAWNEE MISSION
 KROGH MD,STEVE, DODGE CITY
 KROLL MD,HARRY G, TOPEKA
 KRUCKEMYER MD,ALAN L, SALINA
 KRUEGER MD,HAVEN C, GREAT BEND
 KRUEGER MD,KURT ALLEN, SHAWNEE MISSION
 KRUG MD,PAUL E, KANSAS CITY
 KRUPKA MD,JOHN J, WICHITA
 KUBIN MD,DORIS A, SHAWNEE MISSION
 KUBIN,SUSAN D, WICHITA
 KUBINA MD,GLENN RICHARD, WICHITA
 KUEBLER MD,KEVIN M, SHAWNEE MISSION
 KUMAR MD,ARUN, WICHITA
 KUMAR MD,RENU, EMPORIA
 KUMAR MD,SURINDER, NEWTON
 KUMMER,ANTHONY J, KANSAS CITY,MO
 KURTH MD,C JOSEPH, WICHITA
 KURTH MD,ROBERT H, SHAWNEE MISSION
 KUTILEK MD,FRANK J, WICHITA
 KWEE MD,STOE T, KANSAS CITY
 KYI MD,WIN M, DODGE CITY

L

LABHSETWAR MD,S A, JUNCTION CITY
 LACCHEO MD,MICHAEL L, TOPEKA
 LAFENE MD,BENJAMIN W, MANHATTAN
 LAHAM MD,ALEXANDER J, DALLAS,TX
 LAI MD,JENG Y, WICHITA
 LAI MD,MAX G, TOPEKA
 LAING MD,ROBERT R, KANSAS CITY
 LAIRD MD,DALE D, OLATHE
 LANCE JR MD,JOHN F, WICHITA
 LANCE MD,RAYMOND W, PITTSBURG
 LANG MD,GORDON, WAKEENEY
 LAPI MD,RUTH M, SHAWNEE MISSION
 LARSON MD,DANUTA OKTAWIEC, SHAWNEE MISSION
 LARSON MD,DELBERT L, HIAWATHA
 LASH MD,RAY E, SHAWNEE MISSION
 LASLEY MD,MICHAEL B, HAYS
 LASNIER,JOSEPH M, KANSAS CITY
 LATIMER MD,KATHERINE, WICHITA
 LAUDERT,SUSAN E, WICHITA
 LAUNEY MD,WALTON S, TOPEKA
 LAURY MD,DAVID G, SAVANNAH,GA
 LAUVER MD,MARY ANN, WICHITA
 LAVA MD,CHIRUND, PARSONS
 LAW MD,FINDLEY, ELLINWOOD
 LAWHEAD,JEFF D, KANSAS CITY
 LAWHORN MD,CHARLTON D, KANSAS CITY
 LAWHORN MD,STEPHANIE LU, KANSAS CITY
 LAWLESS MD,HAROLD L, BLUE RAPIDS

LAWN MD,CLAUDIA A, WICHITA
 LAWN MD,RAYMOND A, WICHITA
 LAWRENCE MD,GILBERT A, SALINA
 LAWRENCE MD,LINDA M, SALINA
 LAWSON MD,DWIGHT, TOPEKA
 LAWTON MD,MARVIN K, CONCORDIA
 LAWTON,STEVEN K, LITTLE ROCK,AR
 LAWWILL MD,THEODORE, KANSAS CITY
 LAYBOURNE JR MD,PAUL C, KANSAS CITY
 LE MD,CHUONG DUC, GARDEN CITY
 LEAHY MD,JAMES D, SHAWNEE MISSION
 LEAR,REX V, WICHITA
 LEARNED MD,GEORGE R, LAWRENCE
 LEATHERS MD,HOLLIS K PAT, SHAWNEE MISSION
 LEAVELL,MICHAEL E, BALLWIN,MO
 LEE JR MD,EDWARD S, WICHITA
 LEE MD, JAMES G, SHAWNEE MISSION
 LEE MD,JAE M, KANSAS CITY
 LEE MD,KYO R, KANSAS CITY
 LEE MD,MARTIN W, WICHITA
 LEE MD,R REX, WICHITA
 LEE MD,SONG DOW, TOPEKA
 LEE MD,SONG PING, TOPEKA
 LEE MD,YONG U, EL DORADO
 LEFFINGWELL MD,BRUCE L, WICHITA
 LEFFLER MD,PAUL B, PITTSBURG
 LEGASPI JR MD,PEDRO L, SHAWNEE MISSION
 LEGER MD,LEE H, FT MYERS,FL
 LEHMAN,KARL D, KANSAS CITY
 LEIFER MD,WILLIAM N, TOPEKA
 LEIS MD,EDWARD A, WICHITA
 LEISY MD,GERALD W, WICHITA
 LEITCH MD,DAVID A, GARNETT
 LEITNER MD,YORAM B, WICHITA
 LEMONE JR MD,ALBERT N, KANSAS CITY
 LEMONS MD,STEPHEN F, ANDOVER
 LENEVE MD,ROBERT T, PERKINS,OK
 LENSKI JR MD,FRANCIS X, IOLA
 LENTZ MD,WILLIAM R, TOPEKA
 LEO MD,WILLIAM A, KANSAS CITY
 LEPSE MD,PETER S, TOPEKA
 LESKO MD,PAUL D, WICHITA
 LESSENDEN JR MD,C M, TOPEKA
 LESSER MD,DANE A, HUTCHINSON
 LESSIN,DIANNA L, KANSAS CITY,MO
 LESTER MD,JOHN BUCKLES, SHAWNEE MISSION
 LETOURNEAU,EDWARD N, SHAWNEE MISSION
 LETTNER MD,HANS T, HUTCHINSON
 LEVINE MD,ERROL, KANSAS CITY
 LEVINE MD,WILLIAM R, WICHITA
 LEVY MD,EDWIN Z, TOPEKA
 LEWIN MD,WALTER, SHAWNEE MISSION
 LEWIS MD, H. MICHAEL, WICHITA
 LEWIS MD,JAMES E, SHAWNEE MISSION
 LIBEL,ROY, SHAWNEE MISSION
 LICHTY,DAN M, SHAWNEE MISSION
 LIEBERMAN MD,BRUCE IRWIN, KANSAS CITY
 LIES MD,RICHARD B, WICHITA
 LIESMANN MD,GEORGE E, TOPEKA
 LIESMANN MD,JEAN ELIZABETH, TOPEKA
 LILLICH,MAUREEN A, SHAWNEE MISSION
 LIN MD,JOE J, WICHITA
 LIND II MD,EDWARD J, GARDEN PLAIN
 LINDHOLM MD,GERALD R, NEWTON
 LINDSLEY MD,CAROL B, KANSAS CITY
 LINDSTROM,LORI A, KANSAS CITY,MO
 LINHARDT MD,RONALD D, WICHITA
 LINN MD,CATHERINE P, KANSAS CITY
 LIPOFF MD,JAY I, LEAVENWORTH
 LISTERMAN MD,JOHN C, SALINA
 LITTELL MD,JAMES A, WICHITA
 LITTLE MD,L GILBERT, WICHITA
 LIU MD,ALBERT T, KANSAS CITY
 LIU MD,CHIEN, KANSAS CITY
 LIU MD,JOHNS N, SHAWNEE MISSION
 LIVINGSTON D.O.,DOUGLAS R, WICHITA
 LIVINGSTON MD,CHARLES E, SALINA
 LLOYD MD,JOHN C, EMPORIA
 LOCKE MD,MARLIN K, WAKEENEY
 LOCKHART MD,JOSEPH G, WICHITA
 LOEB MD,ELBIE L, HAYS
 LOEFFLER MD,JAMES A, WICHITA
 LOEWEN MD,HENRY H, WICHITA
 LOEWEN MD,WILLIAM C, WICHITA
 LOGAN MD,GEOFFREY G, WICHITA
 LOGAN MD,WILLIAM S, TOPEKA
 LOGANBILL MD,VARDEN J, MOUNDRIDGE
 LOHMEYER MD,KENNETH L, GREEN VALLEY,AZ
 LOHNES JR MD,JOHN H, WICHITA
 LONEY,PAUL D, KANSAS CITY
 LONG MD,EDWARD E, HUMBOLDT
 LONG MD,LLOYD O, GOODLAND
 LONG MD,ROBERT C, NORTON
 LONG,TERESA D, KANSAS CITY,MO
 LOPEZ,MARIA I, KANSAS CITY
 LORSBACH,ROBERT B, GARDNER
 LORTZ,PHILIP W, KANSAS CITY
 LOSEE MD,JOHN M, WICHITA
 LOVELAND MD,G CHARLES, LAWRENCE
 LOVETT MD,PAUL A, WICHITA
 LOVETT,BRENT R, KANSAS CITY,MO
 LOW MD,HAROLD L, WICHITA
 LOWE MD,STANLEY W, MANHATTAN
 LUALLIN,SCOTT R, KANSAS CITY
 LUBETICH JR,JOHN F, KANSAS CITY
 LUCAS MD,GEORGE L, WICHITA
 LUCAS,EDDY D, KANSAS CITY
 LUCKEROTH,LEAH L, WICHITA
 LUDLOW MD,MICHAEL G, WICHITA
 LUEKEN MD,LUEKE B, WICHITA

LUETJE MD,CHARLES MARION, KANSAS CITY,MO
 LUI MD,NASON, TOPEKA
 LUKENS MD,DAVID, HUTCHINSON
 LUKERT MD,BARBARA P, KANSAS CITY
 LULO MD,ANTONIO R, SHAWNEE MISSION
 LUNA MD,ANTHONY D, WICHITA
 LUNBERRY MD,JULIA J, WICHITA
 LUNGSTROM MD,JACK E, ESTES PARK,CO
 LUZZATI MD,ENZO F, WICHITA
 LYGRISSE MD,DANIEL V, WICHITA
 LYLE,LINDA S, WICHITA
 LYNCH MD,JOHN A, TOPEKA
 LYNCH MD,MARY A, WICHITA
 LYNCH MD,SEAN R, KANSAS CITY
 LYONS JR MD,FRANK C, MANHATTAN
 LYRENE MD,STEPHEN A, TOPEKA

M

MABEN MD,PAMELA S, CHANUTE
 MAC KILLOP JR MD,DANIEL, WINFIELD
 MACDOUGALL MD,MARGARET L, SHAWNEE MISSION
 MACE MD,RONALD D, JUNCTION CITY
 MACFARLANE MD,DOUGLAS B, OLATHE
 MACY MD,NORMAN E, SALINA
 MACY MD,TED L, SALINA
 MADDEN,CATHERINE E, WICHITA
 MADDOX MD,OWEN, WICHITA
 MADER MD,ELAINE M, WICHITA
 MADISON JR MD,WARD N, WICHITA
 MADISON MD,WILLARD A, NORTONVILLE
 MADISON,RANDALL W, SHAWNEE MISSION
 MADRIGAL,MARILU, KANSAS CITY
 MADSEN MD,GLENN L, LAWRENCE
 MAGEE,SHAWN M, SHAWNEE MISSION
 MAGERS,STACEY L, KANSAS CITY,MO
 MAGIDSON MD,ELLIOTT ARTHUR, WICHITA
 MAGSALIN MD,ROMULO D, HAYSVILLE
 MAILMAN MD,GERSHOM, WICHITA
 MAINSTER MD,MARTIN A, KANSAS CITY
 MALLORY MD,JOHN A, SHAWNEE MISSION
 MALONE MD,DAVID G, KANSAS CITY,MO
 MALONE MD,EUGENE M, HALSTEAD
 MALONE,DAVID G, KANSAS CITY,MO
 MANAHAN MD,G EUGENE, LAWRENCE
 MANDELBAUM MD,MARK A, WICHITA
 MANGLER MD,VICTOR R, PLEASANTON
 MANGOLD MD,JOEL VOYCE, KANSAS CITY
 MANGUUGLU MD,ALI B, SALINA
 MANI MD,MANI M, KANSAS CITY
 MANLEY MD,JOSEPH W, SHAWNEE MISSION
 MANNING MD,ROBERT T, WICHITA
 MANSOUR MD,BADIE S, WICHITA
 MANTZ MD,FRANK A, SHAWNEE MISSION
 MARCHBANKS MD,DONALD L, SALINA
 MARGOLIS,MICHAEL T, KANSAS CITY,MO
 MARPLES MD,BRADLEY W, TOPEKA
 MARPLES MD,DOUGLAS, DODGE CITY
 MARR MD,GARRETT L, SHAWNEE MISSION
 MARSH MD,CONNIE M, HALSTEAD
 MARSH MD,GENE E, HALSTEAD
 MARSH MD,HENRY O, WICHITA
 MARSHALL MD,B M, TOPEKA
 MARSHALL MD,GEORGE W, SALINA
 MARSHALL,ROGER W, WICHITA
 MARSHALL,STEPHEN R, WICHITA
 MARTIN JR MD,GLEN E, WICHITA
 MARTIN MD,CLYDE V, SUISUN,CA
 MARTIN MD,DANIEL C, MANHATTAN
 MARTIN MD,JOSEPH P, KANSAS CITY
 MARTIN MD,JUAN E, KANSAS CITY
 MARTIN MD,NORMAN L, KANSAS CITY
 MARTIN MD,OLIVER L, SALINA
 MARTIN MD,RONALD L, KANSAS CITY
 MARTIN MD,WILLIAM O, TOPEKA
 MARTIN,HUGH B, ST LOUIS,MO
 MARTINSON MD,EDWARD E, KANSAS CITY
 MARVEL MD,JAMES EBBERT, ARKANSAS CITY
 MARVIN MD,NORMAN G, SHAWNEE MISSION
 MARX DO,WILLIAM H, SAN FRANCISCO,CA
 MARYMONT JR MD,JESSE H, WICHITA
 MASON MD,ROGER, PRATT
 MASSOTH,SUE V, TOPEKA
 MASTERS MD,FRANCIS W, KANSAS CITY
 MASTIO JR MD,GEORGE J, WICHITA
 MATASSARIN MD,FREDERICK W, WICHITA
 MATHEWS MD,DAVID R, SHAWNEE MISSION
 MATHEWS MD,ROBERT MAJOR, SHAWNEE MISSION
 MATHEWSON MD,HUGH S, KANSAS CITY
 MATTHEW MD,WILLIAM L, OLATHE
 MATTHEWS D.O.,GEORGE E, GARDEN CITY
 MATTHEWS MD,EARL H, SALINA
 MATTICK MD,IRVIN H, HAYS
 MATTIOLI MD,LEONE, KANSAS CITY
 MATZEN,TED A, SHAWNEE MISSION
 MAU MD,WALTER, TOPEKA
 MAUCH,WILLIAM D, KANSAS CITY
 MAUCK MD,HAROLD C, STOCKTON
 MAVEC,JAMES A, KANSAS CITY
 MAWDSLEY MD,MICHAEL W, WICHITA
 MAXFIELD MD,RUSSELL J, COLORADO SPRINGS,CO
 MAXWELL MD,GORDON E, SALINA
 MAXWELL MD,ROBERT A, SHAWNEE MISSION
 MAY MD,KENNETH L, BONNER SPRINGS
 MC FARLAND MD,GRETA S, CHANUTE
 MCALLASTER MD,WENDALE E, GREAT BEND
 MCBOYLE MD,MARILEE, WICHITA
 MCCANN MD,PATRICK E, FORT SCOTT

*Probationary members.

MCCANN MD,WILLIAM E, OLATHE
MCCARTER MD,DUANE K, TOPEKA
MCCARTHY MD,ROBERT P, KANSAS CITY
MCCAUGHEY MD,HUGH W, SHAWNEE MISSION
MCCLANAHAN MD,WARD A, WICHITA
MCCLEAY,PETER D, KANSAS CITY,MO
MCCLELLAN MD,ERNEST L, WICHITA
MCCLELLAN MD,JOHN W, DENVER,CO
MCCOLLUM MD,WILLIAM B, LEAVENWORTH
MCCOMAS JR MD,MARMADE D, TOPEKA
MCCORMICK MD,EUGENE CARL, WELLINGTON
MCCOWEN,HERBERT M, SHAWNEE MISSION
MCCOY MD,C PATRICK, WICHITA
MCCOY MD,CHARLES P, WICHITA
MCCOY MD,CHARLES T, HUTCHINSON
MCCOY MD,MICHAEL T, TOPEKA
MCCOY MD,RONALD, DODGE CITY
MCCRAE MD,SPENCER C, SALINA
MCCULLOUGH MD,JAMES P, WICHITA
MCCULLOUGH MD,ROBERT C, GOODLAND
MCCUNE MD,MARK A, KANSAS CITY
MCDONALD MD,KEVIN R, HAYS
MCDONALD MD,THOMAS L, KANSAS CITY
MCDONOUGH MD,W DAVID, WICHITA
MCEACHEN MD,WILLIAM H, SHAWNEE MISSION
MCELHINNEY MD,CHARLES F, DODGE CITY
MCELROY MD,ROBERT T, TOPEKA
MCELROY MD,WILBUR J, TOPEKA
MCGREGOR,PATRICK E, KANSAS CITY
MCGUIRE MD,WILLIAM F, WICHITA
MCHENRY,TERESSA J, WICHITA
MCKAY MD,ROBERT S, WICHITA
MCKEE MD,LEO F, OCEANSIDE,CA
MCKENNA MD,MICHAEL J, FORT SCOTT
MCKERRACHER MD,ROBERT D, DERBY
MCKINLEY,DOUGLAS L, SHAWNEE MISSION
MCKINNEY D.O. ,SHARON L, TOPEKA
MCKITTRICK MD,RICHARD, SHAWNEE MISSION
MCKNIGHT MD,DAVID E, MANHATTAN
MCKNIGHT MD,ELLIS B, ALMA
MCLAIN MD,KENNETH, RANSOM
MCMMASTER MD, JOHN F, WICHITA
MCMEEKIN MD,SHELLA P, SHAWNEE MISSION
MCMILLAN MD,JOHN H, KANSAS CITY
MCMULLEN MD,BRUCE R, WICHITA
MCMULLEN MD,JOSEPH E, HUTCHINSON
MCNEIL MD,ELBERT D, MANHATTAN
MCNICKLE MD,GEORGE A, WICHITA
MCQUEEN MD,DAVID ARNOLD, WICHITA
MCQUITTY,CHRISTOPHER K, KANSAS CITY
MCQUITTY,DWAYNE A, KANSAS CITY
MCRAE-DENNING MD,PATRICIA, WICHITA
MCWHERTER MD,LOTTIE B, SHAWNEE MISSION
MEANS MD,MILA LEE, VALLEY CENTER
MEBUST MD,WINSTON K, KANSAS CITY
MEDHAT MD,MOHAMED A, KANSAS CITY
MEE MD,ADRIAN W, OLATHE
MEEK JR MD,JOSEPH C, WICHITA
MEEKER II MD,BRUCE P, WICHITA
MEGIBOW MD,ALAN D, TOPEKA
MEIDINGER MD,RAY, HIAWATHA
MEIDINGER MD,RICHARD, TOPEKA
MEIER,PATRICIA A, WICHITA
MELEAN MD,JAIME, WICHITA
MELHAM,THOMAS J, KANSAS CITY
MELHORN MD,J MARK, WICHITA
MELHORN MD,KATHERINE J, WICHITA
MELIN MD,BRUCE D, GARDEN CITY
MELROSE,ZIANA A, SHAWNEE MISSION
MENAKER MD,JEROME S, WICHITA
MENDIONES MD,L MARLENE, WICHITA
MENDIONES MD,RUPERTO D, WICHITA
MENDLICK MD,R MICHAEL, OLATHE
MENEHAN MD,H JAMES, WICHITA
MENHUSEN D.O. ,MONTY J, WICHITA
MENKING MD,F W ANFRED, WICHITA
MENKING MD,SUSAN MARGARET, WICHITA
MENNINGER MD,KARL A, TOPEKA
MENNINGER MD,ROBERT G, TOPEKA
MENNINGER MD,ROY W, TOPEKA
MENNINGER MD,W WALTER, TOPEKA
MENNINGER,BRENT O, KANSAS CITY
MENZIE,LISA D, KANSAS CITY
MERCADER MD,MARIO S, WICHITA
MEREDITH MD,W TOM, WICHITA
MERIFIELD,CHRISTOPHER D, SHAWNEE MISSION
MERKEL MD,EARL D, RUSSELL
MERRIFIELD MD,TERRY S, WICHITA
MERRITT MD,JOE P, OKLAHOMA CITY,OK
MERRITT MD,W HENRY, LEAVENWORTH
MERSHON MD,JAMES C, WICHITA
MESSAMORE,DEBRA L, WICHITA
MESSNER MD,STAN A, WICHITA
METZ,BRIAN A, KANSAS CITY
MEYER MD,O WARREN, TOPEKA
MEYER MD,WARREN E, WICHITA
MEYER,MARK C, KANSAS CITY
MEYERS MD,STEPHEN, GARDEN CITY
MEYERS,JOHN J, KANSAS CITY
MHATRE MD,VIJAY R, TOPEKA
MICHELBACH MD,ALBERT P, WICHITA
MIGLIAZZO MD,CARL V, SHAWNEE MISSION
MIGUELINO MD,OLIVER M, EMPORIA
MIH MD,ALEXANDER, CHANUTE
MILBURN JR MD,MERLE E, LEAVENWORTH
MILFELD MD,DOUGLAS J, WICHITA
MILLER MD,CHARLES H, PARSONS

MILLER MD,DAVID PATERSON, WICHITA
MILLER MD,DEAN M, PARSONS
MILLER MD,DENNIS W, KANSAS CITY
MILLER MD,DON E, WICHITA
MILLER MD,EARL E, PITTSBURG
MILLER MD,ELDEN V, SALINA
MILLER MD,FRANKLIN R, WINFIELD
MILLER MD,FREEMAN LANCE, SHAWNEE MISSION
MILLER MD,HERBERT C, NORFORD,CT
MILLER MD,MONT E, APO NEW YORK,NY
MILLER MD,PHILIP, ANTHONY
MILLER MD,ROBERT E, GARDEN CITY
MILLER MD,ROGER M, DERBY
MILLER MD,STEPHEN FRANCIS, PARSONS
MILLER MD,TODD A, WICHITA
MILLER,DAVID A, KANSAS CITY
MILLER,KEVIN E, WICHITA
MILLIGAN MD,DONALD B, KANSAS CITY
MILLS JR MD,PHILIP E, TOPEKA
MILLS MD,CHARLES D, WICHITA
MILLS MD,MELISSA J, KANSAS CITY,MO
MILLS MD,PHILIP R, WICHITA
MILLS MD,STEPHEN C, HUTCHINSON
MILLS MD,VERNON A, LEAVENWORTH
MILLS,CRAIG G, KANSAS CITY
MILLS,KIRK C, WICHITA
MINGES MD,TIMOTHY J, WESTMORELAND
MINNS MD,GAROLD O, WICHITA
MIRZA MD,MEDO, WICHITA
MISKW MD,DON B W, SHAWNEE MISSION
MITCHELL MD,ALEX C, LAWRENCE
MITCHELL MD,SUE M, KANSAS CITY,MO
MITCHELL,DEANNA SUE, KANSAS CITY
MITTS MD,ERNEST W, BONNER SPRINGS
MODDRELL MD,CAROL A, LAWRENCE
MODELL,ELLEN M, SHAWNEE MISSION
MODLIN MD,HERBERT C, TOPEKA
MOELLER MD,DONALD D, KANSAS CITY
MOFFAT MD,ROBERT E, SHAWNEE MISSION
MOHLER MD,JACK M, ABILENE
MOHR MD,SANDRA N, WICHITA
MONTERO,JR,CARLOS, KANSAS CITY
MONTGOMERY MD,MICHAEL L, EMPORIA
MONTGOMERY MD,THOMAS ALLEN, SABETHA
MONTGOMERYSHORT MD,RUTH G, WICHITA
MOORE JR,DENNIS F, WICHITA
MOORE MD,DENNIS F, WICHITA
MOORE MD,ROBERT, HOISINGTON
MOORE MD,ROBERT F, CANEY
MOORE MD,WAYNE V, KANSAS CITY
MOORE,ROBERT M, KANSAS CITY
MOORE,THOMAS A, KANSAS CITY
MOORHEAD JR MD,F ALLEN, NEODESHA
MORAN MD,JON FREDERICK, KANSAS CITY
MORFFI MD,RAUL R, KANSAS CITY
MORGAN II MD,DAVID LLOYD, OLATHE
MORGAN III MD,LOUIS S, WICHITA
MORGAN MD,JAMES I, WICHITA
MORGAN MD,JOHN L, EMPORIA
MORGAN MD,RANDALL J, WICHITA
MORGAN MD,SCOTT, NEWTON
MORGAN,MICHAEL C, SHAWNEE MISSION
MORGAN,MITCH A, KANSAS CITY
MORITZ MD,RICK S, SHAWNEE MISSION
MORONEY MD,JEAN M, SHAWNEE MISSION
MORRIS MD,MERLE D, TOPEKA
MORRISON MD,IRA R, ATCHISON
MORRISON MD,MICHAEL R, TOPEKA
MORROW MD,THOMAS F, WICHITA
MORTON MD,JOHN E, GARDEN CITY
MORTON MD,ROBERT A, ARKANSAS CITY
MOSER MD,ERNEST C, HOLTON
MOSIER MD,STANLEY JAY, WICHITA
MOWERY MD,WILLIAM E, SALINA
MOWRY MD,GERALD L, MANHATTAN
MOYES,ANDREW L, SHAWNEE MISSION
MUEHLBERGER MD,JAMES J, SHAWNEE MISSION
MUELLER MD,ARNOLD V, TOPEKA
MUELLER MD,J KENT, SHAWNEE MISSION
MUELLER MD,VERNETTE A, WICHITA
MUETH MD,JOAN D, WICHITA
MUKERJEE,SANDEEP, KANSAS CITY
MULLER MD,SAMUEL B, PITTSBURG
MULLINIX MD,JANICE M, WICHITA
MUNDEN MD,FRANK A, SHAWNEE MISSION
MURFITT MD,MALCOLM C, LINDSBORG
MURPHY MD,BARRY L, WICHITA
MURPHY MD,DUANE A, WICHITA
MURPHY MD,JAY W, SHAWNEE MISSION
MURPHY MD,JOHN P, KANSAS CITY
MURPHY MD,PATRICK L, WICHITA
MURPHY MD,PAUL M, WICHITA
MURPHY MD,PAUL W, WICHITA
MURPHY MD,ROBERT C, KANSAS CITY
MURPHY MD,WILLIAM R C, WICHITA
MURPHY,TIMOTHY P, KANSAS CITY,MO
MURPHY,WILLIAM R, KANSAS CITY
MURRAY MD,KENT B, WICHITA
MURRAY MD,W LEE, SHAWNEE MISSION
MURROW MD,R W, SHAWNEE MISSION
MYERS JR MD,EARL B, INDEPENDENCE
MYERS MD,JO ANN, TOPEKA
MYERS MD,W EUGENE, IOLA

N

NABOURS MD,RICHARD D, TOPEKA
NACHTIGALL MD,ANDREW, NEWTON
NADER,DADKAH, KANSAS CITY

NAGARAJU MD,ARRAMRAJU, EMPORIA
NAGLE,KEITH J, KANSAS CITY
NALDOZA JR MD,FAUSTINO M, WELLINGTON
NANNEY MD,GREGORY D, HUTCHINSON
NARCISO MD,VICENTE D, ABILENE
NASH MD,ROBERT A, SHAWNEE MISSION
NATHAN MD,WILLIAM A, TOPEKA
NAUER MD,PAULA LOU, SHAWNEE MISSION
NAVICKAS MD,LEONARD A, SHAWNEE MISSION
NAZARIO,LILIANA E, SHAWNEE MISSION
NEASE JR,DONALD E, WICHITA
NEEF MD,DOUG STEVENS, WICHITA
NEEL MD,WILBUR B, HUTCHINSON
NEFF MD,JAMES R, KANSAS CITY
NEIBURGER MD,JAMES B, SHAWNEE MISSION
NEIGHBOR MD,ERNEST H, KANSAS CITY
NEIGHBOR MD,GAYLORD P, KANSAS CITY
NEIL MD,ROY N, HAYS
NEIS MD,HARRY B, OSAGE BEACH,MO
NEIS MD,PAUL R, KANSAS CITY
NELLIS MD,STEPHANIE F, WICHITA
NELSON JR MD,GUST H, WICHITA
NELSON MD,BRYAN C, SHAWNEE MISSION
NELSON MD,DOUGLAS LEROY, SHAWNEE MISSION
NELSON MD,GERALD D, WICHITA
NELSON MD,JOHN B, SHAWNEE MISSION
NELSON MD,RICHARD O, LAWRENCE
NELSON MD,RUSSELL ALAN, WICHITA
NELSON MD,T EUGENE, FORT SCOTT
NELSON,BRENDA S, KANSAS CITY
NELSON,CHARLES G, SHAWNEE MISSION
NELSON,MARIAN K, WICHITA
NELSON,MARK THEODORE, KANSAS CITY
NELSON,NANCY A, CONCORDIA
NESMITH MD,LESLIE W, WICHITA
NETHERTON MD,DAVID M, WICHITA
NEUENSCHWANDER MD,JOHN, HOXIE
NEUENSCHWANDER MD,JOHN RAND, HOXIE
NEUER MD,FREDERICK S, EMPORIA
NEUFELD,BRENDA G, KANSAS CITY,MO
NEUMANN MD,JAMES W, SALINA
NEVINS MD,RICHARD L, LIBERAL
NEWBY MD,JAMES P, WICHITA
NEWCOMB MD,WARD M, HAYS
NEWLIN,PHILIP L, WICHITA
NEWMAN MD,CARL T, CONCORDIA
NEWMAN MD,CLIFFORD B, PITTSBURG
NEWSOM MD,F CARTER, WICHITA
NEWTH,ROBERT C, SHAWNEE MISSION
NEWTON MD,CHARLES R, FRESNO,CA
NIBBELINK MD,LARRY WAYNE, KANSAS CITY
NICE MD,G WILLIAM, TOPEKA
NICHOLS MD,RICHARD, BASTROP,LA
NICHOLS MD,ROBERT R, FORT SCOTT
NICHOLS,JON CHRISTOPHER, SHAWNEE MISSION
NICKELL MD,WENDELL K, SALINA
NIEDEREE MD,DAVID W, DERBY
NIEDEREE MD,W CURTIS, GREAT BEND
NIELSEN MD,MARY L, WICHITA
NIEMAN MD,JOHN L, SHAWNEE MISSION
NIENSTEDT MD,JOHN F, SUN CITY,AZ
NIGH,STEPHEN S, SHAWNEE MISSION
NIGHTENGALE,DIANE J, KECHI
NIKINIA MD,MORTEZA, GARDNER
NIXON MD,JAMES E, DODGE CITY
NIXON MD,LINDA K, OLATHE
NIXON MD,RICHARD R, SALINA
NIXON MD,WILLIAM A, WICHITA
NIXON, DAVID, KANSAS CITY
NOBLE MD,MARK J, KANSAS CITY
NOORDHOEK MD,LYLE J, KANSAS CITY
NORMAN,BENJAMIN R, WICHITA
NORRIS MD,CHARLEY W, KANSAS CITY
NORRIS MD,ROBERT P, WICHITA
NORTH MD,DORIS G, WICHITA
NORTON MD,ROBERT K, WICHITA
NOSTI MD,JUAN C, SHAWNEE MISSION
NOTHNAGEL MD,ARNOLD F, SHAWNEE MISSION
NOVOTNY MD,PETER C, TOPEKA
NOWLIN MD,NANCY S, WICHITA
NULL MD,WILLIAM G, SALINA
NUNEMAKER MD,MARION E, HUTCHINSON
NYBERG MD,FREDRIK F, TOWANDA
NYE MD,C ERIK, SHAWNEE MISSION

O

O'BOYNICK II MD,PAUL LEONARD, KANSAS CITY
O'BRYAN MD,JAMES J, KANSAS CITY
O'DELL MD,MICHAEL L, KANSAS CITY
O'DONNELL MD,HARRY E, JUNCTION CITY
O'DONNELL,JANAT E, WICHITA
O'NEAL MD,LYNN W, LAWRENCE
O'NEIL MD,ROBERT H, TOPEKA
OBANDO MD,GUILLERMO, SALINA
OBOURN MD,ROBERT L, TOPEKA
OCHSNER MD,BRUCE B, WICHITA
ODENHEIMER MD,BURTRAM J, WICHITA
ODGERS MD,RODNEY K, PITTSBURG
OEHME,STEPHEN F, KANSAS CITY
OELSCHLAGER MD,RONALD D, LAWRENCE
OHMAN MD,RICHARD J, DODGE CITY
OHMART MD,RICHARD V, OAKLEY
OLD MD,JERRY L, ARKANSAS CITY
OLIVE JR,MD,ROBERT J, WICHITA
OLNEY MD,ROBERT D, MANHATTAN
OLSEN MD,PHILLIP S, EL DORADO
OLSEN,TIMOTHY W, KANSAS CITY
OLSON MD,CLITUS W, CHICAGO,IL

*Probationary members.

OLSON MD,DAN E, WICHITA
 OLSON MD,ERWIN T, NEWTON
 OLSON MD,THOMAS H, SHAWNEE MISSION
 OLSON,CAROLYN E, KANSAS CITY
 ONG,CATHERINE M, SHAWNEE MISSION
 OPENSHAW MD,CALVIN R, HUTCHINSON
 ORCHARD MD,RICHARD A, LAWRENCE
 ORR MD,STEVEN M, KANSAS CITY,MO
 ORTH-BAAALMAN MD,DIANE M, WICHITA
 OSBERN MD,LIDA, LAWRENCE
 OSBORNE MD,CONRAD C, WICHITA
 OSE,KEVIN J, KANSAS CITY
 OSGOOD MD,GEORGE M, SHAWNEE MISSION
 OSIO MD,ANTONIO L, WICHITA
 OSOBA MD,WILLIAM G, WICHITA
 OSTER MD,JOYCE A, WICHITA
 OTHMER MD,EKKEHARD, KANSAS CITY
 OTTINGER,CHRISTOPHER M, KANSAS CITY
 OUANO JR MD,BIBIANO B, WICHITA
 OVERFIELD,A SCOTT, KANSAS CITY
 OVERHOLSER MD,NORMAN H, EL DORADO
 OWEN III MD,JAMES W, TOPEKA
 OWEN MD,LARUE W, WICHITA
 OWEN MD,PERE A, WICHITA
 OWEN,MEDGE D, KANSAS CITY,MO
 OXLER JR MD,JOHN EDWARD, KANSAS CITY
 OYER MD, FREDERICK R, HUTCHINSON
 OYLER,JONATHAN M, WELLSVILLE

P

PACE MD,JOHN D, PARSONS
 PAGE MD,RUTH, WICHITA
 PAI MD,RADHA V, PARSONS
 PAI MD,VARADARAJ S, PARSONS
 PAIGE,ANGELA A, KANSAS CITY
 PALAGANAS-TOSCO MD,AMANDA C, MCCLOUTH
 PALMER MD,DAVID L, WICHITA
 PALMER MD,GERALD K, SALINA
 PALMER MD,MARGUERITE L, OBERLIN
 PALMER MD,MARVIN M, KANSAS CITY
 PALMER,APRIL L, KANSAS CITY
 PALMER,GLEN L, KANSAS CITY
 PANICHABHONGSE MD,SAMBHUNDH, RUSSELL
 PAPP JR MD,S DEAN, PITTSBURG
 PARANJOTHI MD,SUBRAMONIAM P, PARSONS
 PARDO MD,LILLIAN G, KANSAS CITY
 PARDO MD,MANUEL P, KANSAS CITY
 PAREKH MD,AJITKUMAR M, KANSAS CITY
 PAREKH MD,MADHAVI A, KANSAS CITY
 PARHAM MD,VERDON W, CHANUTE
 PARK MD,ROGER WALTER, WICHITA
 PARKER MD,HAROLD L, WICHITA
 PARKER MD,ROBERT W, LEAVENWORTH
 PARKER,JULIE A J, KANSAS CITY
 PARKS MD,DOUGLAS S, SYRACUSE
 PARKS,JON C, KANSAS CITY
 PARMAN MD,CRAIG R, GODDARD
 PARMAN MD,ROBERT D, TOPEKA
 PARRA MD,DANIEL C, KANSAS CITY
 PARRA MD,MIGUEL D, KANSAS CITY
 PARRIS MD,ROGER D, FORT SCOTT
 PARSONS,JULIE A, WICHITA
 PASCUA MD,PERCIVAL G, TOPEKA
 PASSMAN MD,STEVEN M, WICHITA
 PASTOR MD,VICTOR HUGO, EMPORIA
 PATEL MD,VINOD, TOPEKA
 PATRICK MD,FRED EDWARD, TOPEKA
 PATRON MD,RICARDO A, EL DORADO
 PATRON,RICARDO F, KANSAS CITY
 PATRON,RUFINO B, KANSAS CITY
 PATTERSON MD,JOHN R, SHAWNEE MISSION
 PATTON MD,J MICHAEL, WICHITA
 PAUL,DAVID M, KANSAS CITY
 PAULEY,JANET K, KANSAS CITY
 PAULS MD,DANIEL N, PARSONS
 PAULS,DAVID G, WICHITA
 PAULS,SCOTT W, KANSAS CITY
 PAULY MD,TIMOTHY R, PRATT
 PAVELONIS,JOEL D, SHAWNEE MISSION
 PAXTON MD,EDWARD SCOTT, WICHITA
 PAY MD,NORMAN T, WICHITA
 PAYNE MD,J RALPH, KANSAS CITY,MO
 PAYNE MD,ROBERT R, TOPEKA
 PAZELL MD,JOHN A, KANSAS CITY
 PEARCE MD,EUGENE W J, SHAWNEE MISSION
 PEARCE MD,LUNETTA M, SHAWNEE MISSION
 PEARSON,MARK A, SHAWNEE MISSION
 PEASE MD,GARY L, HUTCHINSON
 PECK MD,ROGER, GREAT BEND
 PEDERSON MD,ARNOLD M, PLAINVILLE
 PEDRAZA MD,HERNANDO, WELLINGTON
 PEERY MD,WILLIAM H, WICHITA
 PEES MD,GERALD B, APOLLO BEACH,FL
 PEFFLY MD,ELMER D, CHETOPE
 PEIL MD,MICHAEL L, WICHITA
 PELLETIER JR MD,LAWRENCE L, WICHITA
 PENA,ALEJANDRO J, KANSAS CITY
 PENCE MD,CHARLES D, WICHITA
 PENN,CHRISTOPHER C, WICHITA
 PENNER MD,STEVEN D, WICHITA
 PENNER,TIMOTHY M, WICHITA
 PENNINGTON MD,KATHERINE, WICHITA
 PENTECOST MD,RICHARD L, SHAWNEE MISSION
 PENZLER MD,CINDY E, SHAWNEE MISSION
 PERDUE II MD,W LANG, TOPEKA
 PEREIRA MD,WILLY G, ARKANSAS CITY

PERIDO MD,DOMINADOR T, ELKHART
 PERKINS MD,JACK L, HUTCHINSON
 PERRY JR MD,LAWRENCE L, KANSAS CITY
 PERSONS,DIANE L, KANSAS CITY,MO
 PETELIN MD,JOSEPH B, SHAWNEE MISSION
 PETERIE MD,JERRY D, WICHITA
 PETERS MD,THOMAS J, WICHITA
 PETERS,CHRISTOPHER C, SHAWNEE MISSION
 PETERS,ERIC A, WICHITA
 PETERSEN MD,GERALD D, SHAWNEE MISSION
 PETERSEN MD,LAURA J, KANSAS CITY
 PETERSEN,MARK I, SHAWNEE MISSION
 PETERSON JR MD,EVAN A, WATHENA
 PETERSON MD,DEAN L, TOPEKA
 PETERSON MD,JACK T, MANHATTAN
 PETERSON MD,JAMES E, SALINA
 PETERSON MD,ROBERT L, TOPEKA
 PETERSON MD,STACY L, WICHITA
 PETERSON MD,VERNON J, TOPEKA
 PETIT MD,CARL, SHAWNEE MISSION
 PETRIE MD,SAMUEL C, SHAWNEE MISSION
 PETRIK MD,EDWIN L, TOPEKA
 PETERSON MD,CECIL E, SYRACUSE
 PETERSON MD,DENNIS CRAIG, TOPEKA
 PETERSON MD,O'RUTH S, RIDGEVILLE,IN
 PETTIJOHN MD,WALTER J, RUSSELL
 PFUETZE MD,BRUCE L, SHAWNEE MISSION
 PFUETZE MD,KARL D, SHAWNEE MISSION
 PFUETZE MD,ROBERT E, TOPEKA
 PHELPS MD,DAVID WAYNE, FORT SCOTT
 PHILIPP MD,JOSEPH THEODORE, MANHATTAN
 PHILLIPS MD,WARREN G, SHAWNEE MISSION
 PHIPPS MD,JACK G, WICHITA
 PIBURN MD,MARVIN F, WICHITA
 PICKENS MD,ANDREW T, WICHITA
 PIERCE MD,CHARLES F, TOPEKA
 PIERCE MD,DONALD R, TOPEKA
 PIERCE MD,GEORGE E, KANSAS CITY
 PIERSON MD,MARK E, EMPORIA
 PIERSON MD,WEIR, MCPHERSON
 PILCHARD MD,WILLIAM A, SHAWNEE MISSION
 PINKERTON,LYNNE E, WICHITA
 PINKHAM,CHRIS M, KANSAS CITY,MO
 PINSKER MD,JACOB A, WICHITA
 PIPPIN MD,LYNNE K, SHAWNEE MISSION
 PITTS MD,RONALD L, SHAWNEE MISSION
 PIZARRO MD,FE E, WINFIELD
 PLOWMAN MD,CARL W, JEWELL
 PLUMB,RENEE L, KANSAS CITY
 PODREBARAC,FRANCIS A, SHAWNEE MISSION
 POGSON MD,GEORGE W, PITTSBURG
 POKORNY,JOHN C, KANSAS CITY
 POLASEK MD,CARLA L, TOPEKA
 POLINER MD,LAWRENCE R, WICHITA
 POLING MD,TERRY L, WICHITA
 POLLACK MD,SIMON, WICHITA
 POLLMAN MD,STANLEY E, JOPLIN,MO
 POLLOCK MD,ANTHONY G A, WICHITA
 POLLY MD,RICHARD E, TOPEKA
 POLSON MD,ROBERT C, GREAT BEND
 POOLE MD,BERNARD T, WICHITA
 POOLE,EDWARD C, KANSAS CITY
 POONAWALA MD,HUSENI, KANSAS CITY,MO
 PORTER MD,DAVID M, KANSAS CITY
 PORTER MD,GARRY L, WICHITA
 PORTER MD,ROBERT D, TOPEKA
 PORTER MD,SUSAN S, KANSAS CITY
 PORTO JR MD,ANTHONY F, SHAWNEE MISSION
 POSS,WILLIAM B, SAN LEANDRO,CA
 POTTER MD,ROBERT L, KANSAS CITY
 POULOSE,ANIL KUTTIKATT, KANSAS CITY
 POWELL II MD,BENSON M, TOPEKA
 POWELL MD,CAROL W, SHAWNEE MISSION
 POWELL MD,KENNETH A, SHAWNEE MISSION
 POWELL MD,WILLIAM R, TOPEKA
 POWERS MD,G ROBERT, KANSAS CITY
 POWERS MD,HAROLD W, SUN CITY,AZ
 POWERS MD,K DEAN, WICHITA
 PRAEGER MD,MARK A, LAWRENCE
 PRAKALAPAKORN MD,YANYONG, NESS CITY
 PRENDES MD,CARLOS A, SHAWNEE MISSION
 PRENTISS MD,HAROLD, NEWTON
 PRESKORN MD,SHELDON H, WICHITA
 PRESTON MD,DAVID F, KANSAS CITY
 PRESTON MD,KEVIN L, MANHATTAN
 PRESTON MD,RALPH R, TOPEKA
 PRESTON MD,RICHARD, GREAT BEND
 PRETZ MD,JAMES B, KANSAS CITY
 PRICE JR MD,LAURANCE W, TOPEKA
 PRICE MD,JAMES GORDON, KANSAS CITY
 PRICE MD,PETER G, WINFIELD
 PRICE MD,VAUGHAN C, MCPHERSON
 PRIETO MD,JORGE N, KANSAS CITY
 PROCHASKA MD,MARK L, TOPEKA
 PROCHAZKA MD,OTTO F, LIBERAL
 PROKOP MD,BRADFORD S, TOPEKA
 PRONKO MD,MICHAEL J, SHAWNEE MISSION
 PROUD MD,G ONEIL, SHAWNEE MISSION
 PRUITT,DAVID E, KANSAS CITY
 PUCKETT,MICHAEL L, KANSAS CITY
 PUGH MD,DAVID M, KANSAS CITY
 PULLMAN MD,NORMAN K, WICHITA
 PULLUM D.O., RICHARD W, GODDARD
 PURINTON MD,LEW W, WICHITA
 PUTNAM MD,LYLE B, WICHITA
 PYLE MD,LUCIEN R, TOPEKA

Q

QAMAR MD,YUSUF, NEWTON
 QUIGLEY MD,JAMES, SHAWNEE MISSION
 QUIJANO JR MD,RAMON S, STAFFORD
 QUINN MD,CHARLES E, KANSAS CITY
 QUINONES MD,ELADIO A, TAMPA,FL

R

RABE MD,MELVIN A, LEAVENWORTH
 RADOM MD,SANFORD B, FORT SCOTT
 RADOVANOV MD,RADMILA, NEWTON
 RAGHAVAN MD,PARULA P, WICHITA
 RAGHAVAN MD,PRAKASH V, WICHITA
 RAINBOW-EARHART MD,KATHRYN A, TOPEKA
 RAJU MD,A S PADMA, TOPEKA
 RALSTIN MD,JAMES H, SHAWNEE MISSION
 RAMIREZ MD,AUGUSTO H, PITTSBURG
 RAMIREZ MD,IRENE, PITTSBURG
 RAMOS MD,MICHAEL, WICHITA
 RAMSAY MD,GRACE A, TOPEKA
 RAMSEY MD,BARTLETT W, TOPEKA
 RAMZY,MERIT S, KANSAS CITY,MO
 RANDALL MD,GEORGE R, WICHITA
 RANDALL MD,GORDON R, TOPEKA
 RANDES MD,MICHAEL J, WICHITA
 RANDOLPH III,RICHARD J, FAYETTEVILLE,NC
 RANNEY MD,BONNIE M, WICHITA
 RANSELL MD,EDGAR C, TOPEKA
 RANSON MD,JAMES H, TOPEKA
 RAO MD,KAKARALA J, LEAVENWORTH
 RATE MD,PEGGY S, HUTCHINSON
 RATHBUN MD,EDWIN D, LIBERAL
 RATTENNE MD,MITZI E, WELLINGTON
 RAUSA JR MD,FRANCISCO C, WICHITA
 RAUSCH,MICHAEL A, KANSAS CITY
 RAWCLIFFE JR MD,ROBERT A, WICHITA
 RAY,LARRY D, SHAWNEE MISSION
 RAZEK MD,HANA A, WICHITA
 RAZEK MD,ZACK A, WICHITA
 READ MD,WILLIAM T, COFFEYVILLE
 READER MD,G WHITNEY, WICHITA
 REALS MD,THOMAS C, WICHITA
 REALS MD,WILLIAM J, WICHITA
 REAZIN MD,WALTER L, WICHITA
 RECKLING MD,FREDERICK W, KANSAS CITY
 REDDI MD,RAGHUNATH P, WICHITA
 REDDY MD,B N, HILL CITY
 REDDY MD,EASHWER K, KANSAS CITY
 REDDY MD,P JAGANNADHA, HILL CITY
 REDDY MD,SATTI S, DODGE CITY
 REDDY MD,VENUMBABA C, EL DORADO
 REDDY,BEENA M, WICHITA
 REDFORD MD,JOHN W B, KANSAS CITY
 REDMON DO,MARY L, KANSAS CITY
 REEB MD,RONALD JOSEPH, KANSAS CITY
 REECE MD,A THOMEN, GARDNER
 REECE MD,RICHARD J, SALINA
 REED JR MD,WILLIAM O, SHAWNEE MISSION
 REED MD,A J, WICHITA
 REED MD,D CRAMER, WICHITA
 REED MD,DAVID D, WICHITA
 REED MD,JAMES S, LAWRENCE
 REED MD,JAMES STEWART, KANSAS CITY
 REED MD,KENNETH L, KANSAS CITY
 REED MD,RALPH R, LAWRENCE
 REED MD,WILLIAM RANDALL, WICHITA
 REEDER,STEPHEN M, SHAWNEE MISSION
 REESE MD,JACK D, LIBERAL
 REESE MD,JOHN L, LAWRENCE
 REEVES MD,C STEWART, FORT SCOTT
 REGIER MD,DONALD D, WICHITA
 REGIER MD,LADONNA M, COLBY
 REICHENBERGER,RONALD J, KANSAS CITY
 REID MD,DONALD A, COFFEYVILLE
 REINHARDT-WULF MD,TAISSIA L, GARDEN PLAIN
 REINKING MD,VICTOR E, TOPEKA
 REINSEL MD,MARK S, KANSAS CITY
 REINTJES MD,STEPHEN L, SHAWNEE MISSION
 REISMAN MD,MICHAEL ALAN, WICHITA
 REISWIG,GARY W, KANSAS CITY
 REISWIG,JEFFREY SCOTT, WICHITA
 REISZ,COLLEEN C, SHAWNEE MISSION
 REIVICH MD,RONALD S, SHAWNEE MISSION
 RELIHAN MD,DONALD A, WICHITA
 REMPEL MD,JOHN H, WICHITA
 REPLOGLE MD,CHARLES B, GREAT BEND
 RETHORST,RICHARD D, KANSAS CITY
 REUSSER,LAYNE M, WICHITA
 REUSSNER,LEE A, KANSAS CITY
 REYES JR MD,FRANCISCO A, OTTAWA
 REYMOND MD,RALPH D, TOPEKA
 REYNOLDS MD,JEFFREY C, HAYS
 REYNOLDS,MIKE G, WICHITA
 REZAET,SHIRLEY J, WICHITA
 RHOADS MD,ANNE C, KANSAS CITY
 RHOADS MD,JAMES P, WICHITA
 RHOADS MD,JEFFREY P, TOPEKA
 RHODEN MD,CURTIS H, WICHITA
 RHODES II,ROBERT J, SHAWNEE MISSION
 RHODES MD,IVAN E, WICHITA
 RHODES MD,JAMES B, KANSAS CITY
 RHODES MD,LOWELL M, WICHITA
 RICCI MD,ROBERT LAWLER, TOPEKA
 RICE JR MD,FREDERICK A, KANSAS CITY
 RICE MD,BERNARD F, SHAWNEE MISSION

*Probationary members.

RICE,DAVID B, KANSAS CITY
 RICH MD,ELDON S, NEWTON
 RICH MD,JOSEPH E, TOPEKA
 RICH,GARY L, KANSAS CITY
 RICHARDS DO,DOUGLAS C, SALINA
 RICHARDS MD,DALLAS LEE, HAYS
 RICHARDS MD,DENNIS D, CLAY CENTER
 RICHARDS MD,JON F, SALINA
 RICHARDSON MD,J M, TOPEKA
 RICHARDSON MD,JAY L, KANSAS CITY
 RICHARDSON,CURTIS J, WICHITA
 RICHMAN MD,DANA R, COLUMBUS
 RICHMAN MD,DAVID S, COLUMBUS
 RICHTER MD,DON G, SHAWNEE MISSION
 RICK JR MD,GREGORY G, SHAWNEE MISSION
 RICKETTS-KINGFISHER MD,DAVID J, TOPEKA
 RIDDEL MD, STEPHEN JAMES, WICHITA
 RIDER MD,JAMES W, ATCHISON
 RIEDERER MD,ROBERT E, OLATHE
 RIEGER MD,ERNEST H, WICHITA
 RIEKHOF MD,PAUL L, SHAWNEE MISSION
 RIESENMY,BRANDON D, SHAWNEE MISSION
 RIFFEL MD,LAWRENCE D, SHAWNEE MISSION
 RILEY MD,RAY B, KANSAS CITY
 RINDT MD,PHILLIP L, FREDONIA
 RING,KEVIN F, SHAWNEE MISSION
 RIORDAN MD,HUGH D, WICHITA
 RISING MD,JESSE D, KANSAS CITY
 ROACH MD,NEIL E, WICHITA
 ROACH,BARBARA L, GRANDVIEW,MO
 ROAN MD,YEAI, WICHITA
 ROBERSON, CHERYL L, KANSAS CITY
 ROBERTS D.O., ROGER W, WICHITA
 ROBERTS MD,DANIEL K, WICHITA
 ROBERTS MD,RICHARD S, LAWRENCE
 ROBERTS MD,WARREN E, TOPEKA
 ROBERTSON MD,EDWARD J, SHAWNEE MISSION
 ROBERTSON MD,JOSEPH K, WICHITA
 ROBINSON MD,DAVID B, TOPEKA
 ROBINSON MD,DAVID W, SHAWNEE MISSION
 ROBINSON MD,EDGAR L, BELLA VISTA,AR
 ROBINSON MD,G DONALD, WICHITA
 ROBINSON MD,JOHN D, SHAWNEE MISSION
 ROBINSON MD,JOHN E, WICHITA
 ROBINSON MD,RALPH G, KANSAS CITY
 ROBINSON MD,ROBERT H, WICHITA
 ROBINSON,RICHARD K, KANSAS CITY
 ROBISON MD,DAVID E, KANSAS CITY
 ROBL MD,DAVID A, WICHITA
 RODERICK MD,JAMES E, SALINA
 RODRIGUEZ MD,ALBERTO, TOPEKA
 RODRIGUEZ MD,PAUL L, GARDEN CITY
 RODRIGUEZ-RAMOS MD,ERNEST R, BIRMINGHAM,AL
 RODRIGUEZ,BEATRIZ M, WICHITA
 RODRIGUEZTOCKER MD,LILIA, WICHITA
 ROEDER MD,ROBERT E, TOPEKA
 ROGERS MD,ANDREW L, WICHITA
 ROMALIS MD,BRIAN E, WICHITA
 ROME,MICHAEL P, WORTHINGTON,OH
 ROEISER MD,REX S, SALINA
 ROMITO MD,CYNTHIA L, SHAWNEE MISSION
 ROMONDO MD,STEVEN A, OLATHE
 RONSICK,STEVEN O, KANSAS CITY
 ROOK MD,LEE E, KANSAS CITY
 ROOS MD,MAUREEN, WICHITA
 RORABAUGH MD,DONALD C, ABILENE
 ROSALES MD,J EDGAR, SALINA
 ROSE MD,DONALD L, BELLA VISTA,AR
 ROSE MD,GRAHAM C, MANHATTAN
 ROSE MD,SHELBY D, WICHITA
 ROSEN MD,CARL H, PRATT
 ROSEN MD,DAVID, WICHITA
 ROSENBERG MD,ALLAN J, KANSAS CITY
 ROSENBERG MD,STANTON L, SHAWNEE MISSION
 ROSENBERG MD,THOMAS F, WICHITA
 ROSENTHAL MD,STANTON J, KANSAS CITY
 ROSIN,ROBERT L, WICHITA
 ROSS MD,DAVID K, ARKANSAS CITY
 ROSS MD,DENNIS LEE, WICHITA
 ROSS MD,JACK L, TOPEKA
 ROTERT MD,LARRY, TOPEKA
 ROTH MD,ALAN E, KANSAS CITY
 ROTHSTEIN MD,TERRY B, PARSONS
 ROWDON,GREGORY A, SHAWNEE MISSION
 ROWLETT MD,JACK G, PAOLA
 ROY MD,WILLIAM R, TOPEKA
 ROY,RISE J, TOPEKA
 RUBIN MD,HERBERT M, SHAWNEE MISSION
 RUBLE JR MD,JAMES L, OVERBROOK
 RUEB MD,ANDREW E, SALINA
 RUHL,CONSTANCE E, SHAWNEE MISSION
 RUHLEN MD,JAMES L, OLATHE
 RUIZ MD,CARLOS M, GREAT BEND
 RUMINSON MD,RONALD R, PITTSBURG
 RUNDQUIST MD,BETH E, KANSAS CITY
 RUNNELS MD,JOHN B, TOPEKA
 RUPP MD,RICHARD J, TOPEKA
 RUPP,JAMES CLARKE, KANSAS CITY
 RUSSELL MD,BRIAN K, SHAWNEE MISSION
 RUSSELL MD,PHILIP W, WICHITA
 RUTHERFORD,MARK A, SHAWNEE MISSION
 RUZICKA MD,LAWRENCE J, CONCORDIA
 RYAN MD,MICHAEL E, SHAWNEE MISSION
 RYAN,SHERRY L, RAYTOWN,MO
 RYMER MD,ROBERT A, SHAWNEE MISSION
 RYSER MD,CAROL A, KANSAS CITY,MO

SABIN JR MD,GEORGE M, WICHITA
 SACHDEVA MD,REKHA, DODGE CITY
 SACHEN MD,FREDERICK L, SHAWNEE MISSION
 SACK,JOSEPH M, WICHITA
 SADIQ MD,SULEMAN, WICHITA
 SAEED MD,MOHAMMAD, DERBY
 SAFFO MD,KARL S, SHAWNEE MISSION
 SAMUEL MD,CHANDY C, WINFIELD
 SANCHEZ MD,JOSE J, WICHITA
 SANCHEZ MD,ROGELIO, TOPEKA
 SANDENO,CRAIG A, SHAWNEE MISSION
 SANDERS MD,GLORIA D, WICHITA
 SANDERS MD,J ALAN, LAWRENCE
 SANDERS,JAMES E, KANSAS CITY,MO
 SANDERS,KARL A, KANSAS CITY,MO
 SANDNESS,KATHLEEN M, KANSAS CITY
 SANTOS MD,FERMIN M, KANSAS CITY
 SANTOS MD,JOAQUIN G, WICHITA
 SANTOSCOY MD,GILBERT S, WICHITA
 SARGENT MD,JOSEPH D, TOPEKA
 SATHYANARAYANA MD,SARASWATHI, SHAWNEE MISSION
 SAUL MD,F WILLIAM, MECHANICSBURG,PA
 SAWKAR MD,LAXMIDAS A, SHAWNEE MISSION
 SAYLER MD,JEROME, GREAT BEND
 SAYLOR MD,EDWARD H, TOPEKA
 SAYLOR MD,LESLIE L, TOPEKA
 SAYLOR MD,MARK, TOPEKA
 SAYLOR MD,RANDEL L, HUTCHINSON
 SAYLOR MD,STEPHEN, TOPEKA
 SCAMMAN MD,W WKE, TOPEKA
 SCAMMAN,AMY C, KANSAS CITY
 SCANLAN MD,TIMOTHY M, WICHITA
 SCANLON II DO,ROBERT C, SPRINGFIELD,MO
 SCANLON JR MD,JAMES H, HADDAM,CT
 SCANLON MD,EDWARD K, KANSAS CITY
 SCHACK MD,STANLEY H, KANSAS CITY
 SCHAEFER MD,JOSEPH PETER, SHAWNEE MISSION
 SCHELLINGER MD,RICHARD P, EMPORIA
 SCHERMOLY MD,MARTIN J, KANSAS CITY,MO
 SCHILTZ MD,FRANCES, WICHITA
 SCHLACHTER MD,ERNEST R, WICHITA
 SCHLAGHECK MD,JOSEPH G, WICHITA
 SCHLEMMER MD,ROGER B, PITTSBURG
 SCHLICHER MD,JOHN E, WICHITA
 SCHLOESSER MD,HARVEY L, TOPEKA
 SCHLOESSER MD,PATRICIA T, TOPEKA
 SCHLOESSER,ANNE C, KANSAS CITY
 SCHLUETER MD,JOHN J, WICHITA
 SCHMAUS MD,LYLE F, IOLA
 SCHMEIDLER MD,DAVID ALLEN, ARKANSAS CITY
 SCHMIDT MD,HERBERT R, NEWTON
 SCHMIDT MD,MICHAEL J, TOPEKA
 SCHMIDT MD,RAMON WARNER, SALINA
 SCHMIDT,KENLEY D, WICHITA
 SCHMIDT,MARTY L, WICHITA
 SCHNELLE MD,JOACHIM, WICHITA
 SCHNOEBELN MD,RENE E, KINSLEY
 SCHOPF MD,CLIFTON C, WICHITA
 SCHOWENGERDT,ANDREW W, KANSAS CITY,MO
 SCHOWENGERDT,DANIEL B, KANSAS CITY
 SCHRAM MD,PETER CHARLES, TOPEKA
 SCHREFFER MD,ROSEMARY, SHAWNEE MISSION
 SCHROEDER MD,SYDNEY O, LAWRENCE
 SCHROEDER,PATRICK L, KANSAS CITY
 SCHROFF,GREGORY P, KANSAS CITY
 SCHROLL MD,JOHN T, SHAWNEE MISSION
 SCHUETZ MD,PERRY N, GREAT BEND
 SCHUKMAN MD,JAY S, GREAT BEND
 SCHULTZ MD,JAMES E, COUNCIL GROVE
 SCHUPP,ELIZABETH A, SHAWNEE MISSION
 SCHUSTER,MICHAEL R, MIDDLETON,WI
 SCHUYLER,GREGG T, KANSAS CITY
 SCHWARTZ MD,EUGENE W, DODGE CITY
 SCHWARTZ MD,V DEAN, WICHITA
 SCHWEGLER MD,RAYMOND A, LAWRENCE
 SCHWEGLER MD,RAYMOND A, KANSAS CITY
 SCHWORM MD,CURTIS P, KANSAS CITY
 SCLAR MD,WILLIAM C, SHAWNEE MISSION
 SCOTT MD,ALEX, JUNCTION CITY
 SCOTT MD,CHESTER E, SALINA
 SCOTT MD,WILLIAM H, WICHITA
 SCOTT,STEVE G, KANSAS CITY,MO
 SCROGGIE,DANIEL J, PAOLA
 SEAMAN MD,LAUREN I, OLATHE
 SEATON MD,ROBERT D, SALINA
 SEBREE MD,STEVEN G, SALINA
 SEGBRECHT MD,STEPHEN L, LAWRENCE
 SEGIE MD,FLOYD RONALD, PITTSBURG
 SEGRAVES,STEVEN D, SHAWNEE MISSION
 SEGRETO DO,MARY C, TOPEKA
 SEHDEV MD,JOAN, TOPEKA
 SEIDEL,DONALD R, WICHITA
 SEIFERT,EARNEST D, WICHITA
 SEITZ JR MD,JOSEPH E, ELLSWORTH
 SEKAVEC MD,GORDON B, OAKLEY
 SEN SARMA MD,PRONAB K, WICHITA
 SETTLE JR MD,RUSSELL O, SHAWNEE MISSION
 SETTLE SR MD,RUSSELL O, TOPEKA
 SEVIER MD,SAMUEL M, MUSKOGEE,OK
 SEYB,STACY T, SHAWNEE MISSION
 SHAAD MD,DOROTHY J, SHAWNEE MISSION
 SHAFFER MD,PRESTON J, WICHITA
 SHAFFER MD,KATHLEEN BRAY, SHAWNEE MISSION
 SHAH MD,ASHOK H, WINFIELD
 SHAH MD,MIAN, LARNED

SHAH MD,MUKHTAR H, WICHITA
 SHAH MD,NASREEN, LARNED
 SHAH MD,SHARFUDDIN, HALSTEAD
 SHANKER MD,STUART G, OLATHE
 SHAPIRO MD,WILLIAM M, WICHITA
 SHARMA MD,ARUN L, PARSONS
 SHARMA MD,S A, SYRACUSE
 SHAVER,TIM, WICHITA
 SHAW MD,JOSEPH L, TOPEKA
 SHAW MD,RICHARD C, WICHITA
 SHAW,HOWARD A, KANSAS CITY,MO
 SHAW,PAMELA K, SHAWNEE MISSION
 SHEAFOR MD,DOUGLAS, TOPEKA
 SHEARS MD,ROBERT N, HUTCHINSON
 SHECHTER MD,NATHAN, KANSAS CITY,MO
 SHEEHAN,MAUREEN H, SHAWNEE MISSION
 SHEERN MD,MARK DOUGLAS, ABILENE
 SHEFFER MD,KEITH D, OLATHE
 SHEFFIELD MD,MICHAEL A, MANHATTAN
 SHEHI MD,LORA J, GAINESVILLE,FL
 SHELLITO MD,JOHN G, WICHITA
 SHELLITO MD,JOHN L, WICHITA
 SHELTON MD,STEPHEN E, TOPEKA
 SHEPARD MD,LEROY W, LARNED
 SHEPARD,SHELLEY M, SHAWNEE MISSION
 SHEPPARD MD,ROBERT G, SMITH CENTER
 SHERARD,JOHN L, KANSAS CITY
 SHERARD,SARAH L, KANSAS CITY
 SHERBON,MARY LOU, DERBY
 SHERIDAN MD,RANDY M, SHAWNEE MISSION
 SHERMAN MD,ROBERT P, KANSAS CITY
 SHERMAN,DENISE I, DERBY
 SHERVIN MD,ADEL, HUTCHINSON
 SHERWOOD JR MD,CLARENCE E, TOPEKA
 SHEU MD,W ERIC, TOPEKA
 SHIELD MD,CHARLES, WICHITA
 SHIELDS JR MD,JAMES M, EL DORADO
 SHIELDS MD,THOMAS M, MANHATTAN
 SHIPPEY MD,DEAN U, WINFIELD
 SHIVEL MD,DAVID G, GREAT BEND
 SHOFFNER MD,RICHARD W, WICHITA
 SHOFSTALL MD,WILLIAM H, SHAWNEE MISSION
 SHORTES MD,LOIS E, FT BRAGG,CA
 SHRADER MD,C ERIC, WICHITA
 SHRADER MD,DOYLE A, WICHITA
 SHULTZ,WILLIAM H, SHAWNEE MISSION
 SHUMARD,CRAIG J, WICHITA
 SHURTZ MD,GLEN L, WICHITA
 SHUTT MD,CHARLES B, LAWRENCE
 SIDLINGER MD,ROBERT L, TOPEKA
 SIEG,KARL G, SHAWNEE MISSION
 SIEGLE MD,LORA A, WICHITA
 SIEMENS MD,RICHARD A, LYONS
 SIEMENS,CHARLOTTE A, LYONS
 SIFERS MD,TIMOTHY M, SHAWNEE MISSION
 SIFFORD MD,R LAWRENCE, WICHITA
 SILER MD,EUGENE T, HAYS
 SILLS MD,CHARLES T, NEWTON
 SILLS MD,THOMAS D, SHAWNEE MISSION
 SILVER MD,BRADD J, SHAWNEE MISSION
 SIMMONS MD,ROBERT EARLE, NEWTON
 SIMMS MD,DAVID ALAN, WICHITA
 SIMON,CRAIG A, KANSAS CITY
 SIMONY,M ANN, SHAWNEE MISSION
 SIMPSON MD,KAREN M, KANSAS CITY
 SIMPSON MD,ROBERT LIMBAUGH, OBERLIN
 SIMPSON MD,TOM C, STERLING
 SIMPSON MD,WILLIAM S, TOPEKA
 SIMS MD,PETER MORRIS, TOPEKA
 SINNING MD,GARY, HIAWATHA
 SISK MD,PHILLIP B, TOPEKA
 SITZMAN JR MD,EVERETTE, KANSAS CITY
 SIWEK MD,CHRISTOPHER W, EL DORADO
 SKAER MD,STANLEY ALLEN, EUREKA
 SKIBBA MD,RICHARD M, WICHITA
 SKOCH MD,MICHAEL G, WICHITA
 SLAUGHTER ,JERRY, TOPEKA
 SLOO MD,MILO G, SALINA
 SLUTSKY MD,LAWRENCE JOEL, WICHITA
 SMARDO JR,FRED L, KANSAS CITY
 SMITH JR MD,FLOYD L, COLBY
 SMITH JR MD,WILLARD J, WICHITA
 SMITH MD,ALVIN L, WICHITA
 SMITH MD,BOYD E, SALINA
 SMITH MD,BRUCE G, ARKANSAS CITY
 SMITH MD,DALE C, SHAWNEE MISSION
 SMITH MD,DAVID E, SALINA
 SMITH MD,DONALD J, SHAWNEE MISSION
 SMITH MD,HAROLD R, SALINA
 SMITH MD,JOHN D, LARNED
 SMITH MD,JON A, SALINAS,CA
 SMITH MD,LEO A, TOPEKA
 SMITH MD,LINDALL E, WICHITA
 SMITH MD,MONT A, SHAWNEE MISSION
 SMITH MD,NEWTON C, ARKANSAS CITY
 SMITH MD,PERRY MILTON, GREAT BEND
 SMITH MD,THOMAS WILLIAM, HUTCHINSON
 SMITH MD,TIMOTHY WM, WICHITA
 SMITH MD,WILLIAM P, SHAWNEE MISSION
 SMITH,MICHAEL L, KANSAS CITY
 SNARR MD,JACK W, TOPEKA
 SNIDER,BRUCE B, KANSAS CITY
 SNIDER,JOHN M, KANSAS CITY
 SNODELL MD,FIRMIN E, SHAWNEE MISSION
 SNOOK MD,ROBERT RUFUS, MCLOUTH
 SNORTUM MD,ROBERT A, GARDEN CITY
 SNOW JR MD,ARTHUR D, SHAWNEE MISSION
 SNOW MD,DONALD L, LEAVENWORTH
 SNOWBARGER MD,MARVIN D, EMPORIA

*Probationary members.

SNYDER MD,GREGG M, WICHITA
 SNYDER MD,RICHARD HENRY, OLATHE
 SNYDER MD,THOMAS E, KANSAS CITY
 SNYDER,JULIE, KANSAS CITY
 SNYDER,MARK G, KANSAS CITY,MO
 SOELDNER MD,JAMES O, GRANDVIEW,MO
 SOLOMON MD,HERMAN, WICHITA
 SOLTZ MD,ROBERT A, WICHITA
 SOMERS MD,MARVIN M, WICHITA
 SOMMERFIELD,DAVID L, SHAWNEE MISSION
 SONGER MD,HERBERT L, ABILENE
 SOUCEK MD,CHARLES D, KANSAS CITY
 SOUTHERN,FREDRICK N, KANSAS CITY
 SPANN MD,RICHARD W, WICHITA
 SPEARMAN MD,JESSE L, TOPEKA
 SPEARS MD,CHESTER A, EMPORIA
 SPEER MD,LELAND, KANSAS CITY
 SPEER MD,LOUIS N, OTTAWA
 SPENCE MD,MICHAEL D, JETMORE
 SPENCER MD,JOHN HAROLD, FORT SCOTT
 SPENCER MD,MILLARD C, TOPEKA
 SPENCER MD,WAYNE E, TOPEKA
 SPERRY MD,ROBERT E, KANSAS CITY
 SPIKES MD,MARION E, GARDEN CITY
 SPILKER,CYNTHIA A, KANSAS CITY
 SPITTLER MD,LEO J, SHAWNEE MISSION
 SPRITZER MD,JEROME S, HUTCHINSON
 SPRADLIN,MICHAEL L, SHAWNEE MISSION
 SPRATT MD,DENNIS P, WICHITA
 SPRINGER,MARK J, WICHITA
 STACEY MD,KIMBALL, INDEPENDENCE
 STADALMAN MD,ROSS EUGENE, HAYS
 STAFFORD MD,ROBERT W, HUTCHINSON
 STAMBAUGH MD,ROY A, WICHITA
 STAMPS MD,PHIL, WICHITA
 STANDLEE MD,TIM E, OLATHE
 STANLEY MD,DANIEL S, WICHITA
 STANLEY MD,KENNETH E, FT WAYNE,IN
 STANLEY MD,REX C, PAOLA
 STANLEY,BRAD K, SHAWNEE MISSION
 STANLEY,KENNETH E, WICHITA
 STARK MD,JAMES R, WICHITA
 STARKEY MD,JERALD L, RUSSELL
 STARKEY,DAVID J, WICHITA
 STARR,STEVEN K, KANSAS CITY
 STASS-ISERN MD,MERRILL, KANSAS CITY,MO
 STAUDACHER,TIMOTHY P, SHAWNEE MISSION
 STECH MD,JOSEPH M, ANDALE
 STECHSCHULTE JR,DANIEL J, KANSAS CITY
 STECKLEY MD,RICHARD ALLEN, WICHITA
 STEEGMANN MD,A THEODORE, INDIANAPOLIS,IN
 STEELBERG MD,ELSIE, WICHITA
 STEELE MD,CLARENCE H, KANSAS CITY
 STEEVES MD,JOHN H, EMPORIA
 STEEVES,KIMBERLY J, KANSAS CITY
 STEICHEN MD,EDWARD F, LENORA
 STEIN MD,JOSEPH M, TOPEKA
 STEIN MD,PAUL S, WICHITA
 STEINBERGER,CRISTINE C, SHAWNEE MISSION
 STEINKRUGER MD,VERLYN WILLIAM, SMITH CENTER
 STEINZEIG MD,SHERMAN M, KANSAS CITY
 STEMBRIDGE MD,TRAVIS W, WICHITA
 STEPHANZ JR MD,GERALD B, GAINESVILLE,FL
 STEPHENS DO,GORDON M, WICHITA
 STEPHENS MD,CHARLES, MINNEOLA
 STEPHENSON MD,LUCILLE C, ST FRANCIS
 STEVENS MD, WM. MICHAEL, WICHITA
 STEVENS MD,LEAH J, LEAVENWORTH
 STEVENS MD,MILDRED J, GARNETT
 STEVENS MD,PHILIP L, TONGANOXIE
 STEVENS MD,RONALD, NEWTON
 STEVENSON MD,E KENT, SHAWNEE MISSION
 STEWART,DANIEL L, WICHITA
 STILES MD,MICHAEL C, KANSAS CITY,MO
 STINGO,ANDREW J, STILWELL
 STOCK MD,KARL W, TOPEKA
 STOCKWELL MD,MORGAN U, DODGE CITY
 STOFER MD,BERT E, PRESCOTT,AZ
 STOFFER MD,ROBERT P, HALSTEAD
 STONE MD,CHESTER W, EMPORIA
 STONE MD,C REX, MANHATTAN
 STONE MD,GRANT C, ATTICA
 STONE,CHRIS D, KANSAS CITY
 STOSKOPF MD,LAWRENCE E, SALINA
 STOUT MD,JAMES M, HUTCHINSON
 STOUT MD,NILES M, LYNDON
 STRAIN,LORRAINE L, WICHITA
 STREET MD,DAVID E, WICHITA
 STREIT MD,JEROME G, WICHITA
 STRIEBINGER MD,CHARLES M, SHAWNEE MISSION
 STRONG,BRADLEY W, OLATHE
 STRUTZ MD,WILLIAM C, LEAVENWORTH
 STRYKER JR MD,HENRY B, CONCORDIA
 STUART,SCOTT P, KANSAS CITY
 STUBBLEFIELD MD,CHARLES T, KANSAS CITY
 STUBER MD,JACK LAWRENCE, SHAWNEE MISSION
 STUBLER,DANIEL K, KANSAS CITY
 STUCKEY MD,CHARLES E, SHAWNEE MISSION
 STUCKY MD,DEAN E, MEDICINE LODGE
 STUEVER,KEVIN J, KANSAS CITY,MO
 STUEWE MD,BRADLEY R, SALINA
 STUMP MD,HARL G, HAYS
 SUERO MD,JESUS T, WICHITA
 SUFI MD,M ASHRAF, TOPEKA
 SUGAR MD,ROBERT L, SHAWNEE MISSION
 SUITER MD,DANIEL JAY, PRATT
 SULLIVAN JR MD,HENRY B, SHAWNEE MISSION
 SULLIVAN MD,CORNELIUS J P, FISHKILL,NY

*Probationary members.

SULLIVAN MD,LEONARD L, WICHITA
 SULLIVAN MD,TOM G, SHAWNEE MISSION
 SUMMERS,LAURIE K, WICHITA
 SUMNER MD,JOYCE R, HUTCHINSON
 SUMNER MD,MARION M, HUTCHINSON
 SUMNER MD,RALPH N, FREDONIA
 SUTTON JR MD,RICHARD L, SHAWNEE MISSION
 SUTTON,JEFFREY J, KANSAS CITY
 SVOBODA MD,CHARLES R, CHAPMAN
 SVOBODA MD,LOIS V, WICHITA
 SVOBODA MD,WILLIAM B, WICHITA
 SWAN MD,MAJOR MARTIN, AUBURN,CA
 SWANN MD,CLAIR L, RUSSELL
 SWARTZ MD,WARREN E, ANCHORAGE,AK
 SWARTZ,MARSHA A, WICHITA
 SWEAZY,SCOTT M, SHAWNEE MISSION
 SWEET MD,DONNA E, WICHITA
 SWEET,LEIGHTON J, KANSAS CITY
 SWOGGER JR MD,GLENN, TOPEKA

T

TABOR MD, REGAN W, WICHITA
 TACKETT MD,RUSSELL E, SHAWNEE MISSION
 TACKETT,ROBERT J, WICHITA
 TALBERT,TIMOTHY C, WICHITA
 TANANUNKUL MD,URAIWAN, PARSONS
 TANDOC JR MD,VALENTIN T, NEWTON
 TANG MD,CHANTRA, PARSONS
 TANG MD,SAROLD, PARSONS
 TAPHORN,ANN M, KANSAS CITY
 TAPPEN MD,DANIEL L, TOPEKA
 TARANTINO,CELESTE A, KANSAS CITY
 TARGOWNIK MD,KARL K, TOPEKA
 TARNOWER MD,WILLIAM, TOPEKA
 TATPATI MD,DANIEL A, WICHITA
 TATPATI MD,OLGA ADELINA, WICHITA
 TAWIL MD,ELIAS ADIB, PITTSBURG
 TAYIEM MD,A K, ATCHISON
 TAYLOR MD,BARBARA D, MANHATTAN
 TAYLOR MD,ELMER W, SEDAN
 TAYLOR MD,ELWYN J, HUTCHINSON
 TAYLOR MD,STEVEN L, WICHITA
 TAYLOR MD,THOMAS F, SALINA
 TAYLOR MD,THOMAS L, SHAWNEE MISSION
 TAYLOR MD,WILLIAM F, KANSAS CITY
 TEARE MD,MAX E, GARDEN CITY
 TEETER,CAROLYN NAN, KANSAS CITY
 TEETER,MARILYN A, KANSAS CITY
 TEJANO MD,NEONILIO A, HALSTEAD
 TEMPERO MD,STEPHEN J, TOPEKA
 TEMPLETON MD,ARCH W, KANSAS CITY
 TENNY MD,ROBERT T, SHAWNEE MISSION
 TERREBONNE MD,MAE E, WICHITA
 TETER,KENNETH E, WICHITA
 TETZLAFF MD,ARCH O A, WEATHERBY LAKE,MO
 THEDINGER MD,BRADLEY S, KANSAS CITY,MO
 THELEN MD,J CHRISTINE, WICHITA
 THEROU MD,LEONA F, KANSAS CITY
 THIEMANN D.O. A H, SUBLETTE
 THOMAS MD,GREGORY MCQUEEN, MCPHERSON
 THOMAS MD,JAMES H, KANSAS CITY
 THOMAS MD,MARTY H, SHAWNEE MISSION
 THOMAS,STANLEY M, SHAWNEE MISSION
 THOMPSON MD,DANIEL M, WICHITA
 THOMPSON MD,DANNIE M, KANSAS CITY
 THOMPSON MD,WILLIAM E, WICHITA
 THOMS MD,NORMAN W, TOPEKA
 THOMSEN MD,GARY, SHAWNEE MISSION
 THORNTON III,FOXHALL P, SHAWNEE MISSION
 THORNTON JR MD,FOXHALL P, CONCORDIA
 THORNTON MD,JAMES L, FORT SCOTT
 THORNTON,CAROLYN SUE, SHAWNEE MISSION
 THORNTON,REBECCA R, WICHITA
 THORPE MD,FRANCIS A, PRATT
 THURSTON MD,DAVID E, TOPEKA
 TICKLES MD,DEBRA F, KANSAS CITY
 TIEMANN MD,WILLIAM H, MANHATTAN
 TIETZE MD,DENNIS D, TOPEKA
 TIHEN MD,EDWARD N, WICHITA
 TILLER MD,GEORGE R, WICHITA
 TILLOTSON MD,DON R, ULYSSES
 TILTON MD,FRANK M, WICHITA
 TINTEROW MD,MAURICE M, WICHITA
 TIOJANCO MD,REYNALDO R, KANSAS CITY
 TIPPIN JR MD,ERNEST E, WICHITA
 TIPTON,KYLE M, KANSAS CITY
 TIVORSK MD,ARKOM, ATCHISON
 TOALSON MD,WILLIAM B, SHAWNEE MISSION
 TOBIAS MD,ROGER R, LYONS
 TOCKER MD,ALFRED M, WICHITA
 TOLLEFSON,DENISE D, KANSAS CITY,MO
 TONKOWICZ,PATRICIA A, SHAWNEE MISSION
 TONN MD,GERHART R, WICHITA
 TOOHEY MD,JOHN S, WICHITA
 TORREY,ELIZABETH A, DURHAM,NC
 TOSH MD,FRED E, WICHITA
 TOZER MD,RICHARD C, TOPEKA
 TRACY MD,TERRY A, WICHITA
 TRAN MD, TUONG M, AUGUSTA
 TRAVERS MD,HENRY, WICHITA
 TRAVIS MD,JOHN W, TOPEKA
 TREES MD,DONALD P, HOLLYWOOD,CA
 TREGER MD,NEWMAN V, TOPEKA
 TREGO MD,ANDREW J, WICHITA
 TREKELL MD,WILLIAM V, DODGE CITY
 TRETBAR MD,HARVEY A, WICHITA
 TRETBAR MD,LAWRENCE L, SHAWNEE MISSION
 TREWEEKE MD,MICHAEL W, WICHITA

TRIMBLE SR MD,DAVID P, EMPORIA
 TRIMMER,KENNETH J, WICHITA
 TRILO MD,PETER A, GARDEN CITY
 TROTTER MD,ROGER COURTNEY, DODGE CITY
 TROWBRIDGE,DENISE R, SHAWNEE MISSION
 TRUDEAU MD,DAVID L, WICHITA
 TRUEWORTHY MD,ROBERT C, KANSAS CITY
 TRUJILLO MD,ANTERO A, WICHITA
 TSCHOPP MD,CHARLES F, ANCHORAGE,AK
 TSEN,ANDREW C, KANSAS CITY
 TUCKER MD,DONALD R, TOPEKA
 TUCKER MD,SHERIDAN G, SHAWNEE MISSION
 TUCKER MD,VIRGINIA L, TOPEKA
 TURKLE,JANET K, MULVANE
 TURLEY,HAROLD M, FORT WORTH,TX
 TURNER MD,JOHN W, GARDEN CITY
 TURNER MD,MARC A, SHAWNEE MISSION
 TURNER,ROBERT N, WICHITA
 TURNER,WADE A, WICHITA
 TWEET MD,FREDRICK A, PITTSBURG
 TWEITO MD,DAVID H, HUTCHINSON

U

UBELAKER MD,ERNEST J, SOUTH HAVEN
 UHLIG MD,PAUL J, WICHITA
 UHR MD,NATHANIEL, TOPEKA
 UNDERWOOD MD,CHARLES C, EMPORIA
 UNREIN MD,ROBERT J, GREAT BEND
 UNRUH MD,GREGORY K, KANSAS CITY
 UNRUH,LINDA SUE, SHAWNEE MISSION
 UNTERMAN MD,STEVEN R, KANSAS CITY
 UTLEY MD,JAMES HARMON, KANSAS CITY,MO
 UY MD,WILSON O, COFFEYVILLE

V

VACEK MD,JAMES L, KANSAS CITY
 VACHAL MD,EVA, GARDEN CITY
 VAL-MEJIAS MD,JESUS E, WICHITA
 VALK MD,WILLIAM L, SHAWNEE MISSION
 VAN DE VEER,SCOTT M, KANSAS CITY,MO
 VAN DOREN,BRYAN A, GARDEN CITY
 VAN HOUDEN MD,CHARLES E, CHANUTE
 VAN LEEUWEN MD,GERARD J, WICHITA
 VAN SICKLE MD,GREGGORY J, TOPEKA
 VANDE GARDE MD,LARRY D, TOPEKA
 VANDER VELDE MD,STANLEY LEROY, EMPORIA
 VANNAMAN MD,DONALD D, SHAWNEE MISSION
 VARADHAN MD,JANAKI, PRATT
 VARENHORST MD, MICHAEL P, WICHITA
 VARGHESE MD,GEORGE, KANSAS CITY
 VASU MD,M ANDRE, TOPEKA
 VASUDEVAN,GOPI, WICHITA
 VATS MD,TRIBHAWAN S, KANSAS CITY
 VAUGHAN MD,D ANN, WICHITA
 VENNEMAN II,CHARLES R, ROCHESTER,MN
 VERMA MD,ASHA, PARSONS
 VERNON MD,MARY C, LAWRENCE
 VESOM MD,PITT, ATCHISON
 VIERTHALER MD,CARL A, DODGE CITY
 VIERTHALER MD,LYLE D, HUTCHINSON
 VIERTHALER MD,STEPHEN L, DODGE CITY
 VILE,SHELDON B, SHAWNEE MISSION
 VIN ZANT MD,LARRY E, DERBY
 VINE MD,DONALD LEE, WICHITA
 VINZANT MD,MARK N, DERBY
 VINZANT MD,WHITNEY L, WICHITA
 VOGEL MD,STANLEY J, TOPEKA
 VOGELSANG,PAMELA J, KANSAS CITY,MO
 VOGT MD,VERNON W, NEWTON
 VOLKMAN II MD,HARLEY W, MANHATTAN
 VON LEONROD JR MD,GEORGE, DIGHTON
 VON RUDEN MD,WILLIAM J, HUTCHINSON
 VOORHEES MD,CARROLL D, LEAVENWORTH
 VOORHEES MD,GORDON S, LEAVENWORTH
 VORAN,DAVID A, SHAWNEE MISSION
 VOTAPKA MD,WILLIAM L, STOCKTON
 VOTH MD,DOUGLAS W, WICHITA
 VOTH MD,ERIC A, TOPEKA

W

WADE MD,EDWARD J, WICHITA
 WADE MD,THEODORE E, LIBERAL
 WADUD MD,ABDUL, WICHITA
 WAGENBLAST MD,HOWARD R, SALINA
 WALDORF JR MD,MELVIN H, GREENSBURG
 WALIA MD,JAG M, TOPEKA
 WALKER D.O., MARSHALL D, WICHITA
 WALKER MD,JACK D, SHAWNEE MISSION
 WALKER MD,MAURICE A, KANSAS CITY
 WALKER MD,NELLIE G, LEE'S SUMMIT,MO
 WALKER MD,WILLIAM H, ESKRIDGE
 WALKER MD,WILLIAM K, SEDAN
 WALKER MD,WILLIAM L, SHAWNEE MISSION
 WALKER,ANDY E, KANSAS CITY
 WALLACE JR MD,WAYNE O, ATCHISON
 WALLACE MD,LEO F, TOPEKA
 WALLING MD,ADRIAN E, WICHITA
 WALLING MD,ANNE D, WICHITA
 WALLS MD,WILLIAM J, TOPEKA
 WALSH MD,DAVID J, KANSAS CITY
 WALSH MD,THOMAS E, ONAGA
 WALTERS MD,BYRON W, SUN CITY,AZ
 WALTERS MD,WILLIAM DAVID, KANSAS CITY
 WALTON MD,PHILIP D, HORTON

WALZ MD,ROYCE C, TOPEKA
 WALZ MD,THOMAS J, TOPEKA
 WAMSLEY,CRAIG A, TULSA,OK
 WANG MD,SIDNEY W, SHAWNEE MISSION
 WANLESS MD,KIRK M, TOPEKA
 WARD MD,HOWARD N, TOPEKA
 WARD MD,JAMES A, BELLEVILLE
 WARD MD,LARRY G, WICHITA
 WARD MD,ROBERT L, PRATT
 WARD,CYNTHIA L, WICHITA
 WARD,WENDY L, SHAWNEE MISSION
 WARDEN,SUSAN K, KANSAS CITY
 WARE MD,LUCILE M, TOPEKA
 WARNER MD,RICHARD B, SHAWNEE MISSION
 WARNER,CLAUDE A, KANSAS CITY
 WARREN JR MD,JOHN W, WICHITA
 WARREN MD,LINDA D, HANOVER
 WARREN MD,LLOYD P, WICHITA
 WARREN MD,ROGER D, HANOVER
 WARREN MD,WIRT A, WICHITA
 WARRICK MD,DAVID ALAN, TOPEKA
 WATANABE,MASAYO, KANSAS CITY,MO
 WATERS MD,CLARENCE N, SALINA
 WATERS MD,DALE A, TOPEKA
 WATSON MD,RICHARD L, WICHITA
 WATTERS,AARON T, SHAWNEE MISSION
 WATTS MD,GARRETT E, WICHITA
 WATTS MD,HARRY E, HAYS
 WAXMAN MD,DAVID, SHAWNEE MISSION
 WAXMAN,STEVE, SHAWNEE MISSION
 WEAVER MD,J ROBERT, WICHITA
 WEAVER MD,JACK D, WICHITA
 WEAVER MD,WALTER D, TOPEKA
 WEBB MD,JAMES R, SHAWNEE MISSION
 WEBER JR MD,HUGO P, WICHITA
 WEBER MD,ALICE, WICHITA
 WEBER MD,DARRELL J, TOPEKA
 WEBER MD,ROBERT W, SALINA
 WEBER MD,WALLACE N, HAYS
 WEBSTER MD,BOBBY W, WICHITA
 WEDDLE MD,DOUGLAS P, FORT SCOTT
 WEDEL MD,ALAN K, MINNEAPOLIS
 WEDEL MD,KENNETH D, MINNEAPOLIS
 WEDEL MD,KERMIT G, MINNEAPOLIS
 WEGNER MD,MARY M, TOPEKA
 WEIDENSAUL MD,D N, HUTCHINSON
 WEIGAND MD,JOEL T, WELLINGTON
 WEIGEL MD,JOHN W, KANSAS CITY
 WEINGART,JAMES H, SHAWNEE MISSION
 WEINSTEIN,GARY L, SHAWNEE MISSION
 WEIPPERT MD,EDWARD J, WICHITA
 WEISHAAR,PAUL D, WICHITA
 WELCH MD,JACK W, HALSTEAD
 WELCH MD,KATHRYN E, LEAVENWORTH
 WELCH MD,LAUREN A, GARDEN CITY
 WELCH MD,LAUREN K, WICHITA
 WELCH MD,MAURA S, WAMEGO
 WELLING,PAUL A, SHAWNEE MISSION
 WELLS MD,MAX MICHAEL, WICHITA
 WELLSHEAR MD,CHARLES C, WICHITA
 WELSH MD,NANCY JANE, TOPEKA
 WELTNER MD,ROGER P, BELOIT
 WELTON,THOMAS C, SHAWNEE MISSION
 WENDELBURG,BLAKE E, KANSAS CITY
 WENGER MD,GREGG D, SABETHA
 WENGER,CHARLES B, KANSAS CITY
 WENGER,CHARLES B, KANSAS CITY
 WENINGER MD,JOHN H, WICHITA
 WERNER MD,WILLARD F, TRIBUNE
 WERTH MD,DARREL D, HAYS
 WERTZBERGER MD,JOHN, LAWRENCE
 WESCOE MD,W CLARKE, SPICER,MN
 WEST MD,WILLIAM T, WICHITA
 WETZEL,MARK D, KANSAS CITY
 WETZEL,ORVILLE R, KANSAS CITY
 WEYDERT,JOY A, KANSAS CITY
 WHEELER MD,DWIGHT E, NEWTON

*Probationary members.

WHEELER MD,NICKY RAY, WICHITA
 WHEELER MD,PINCKNEY R, WICHITA
 WHEELER,JAMES A, WICHITA
 WHITACRE MD,MARC M, KANSAS CITY
 WHITAKER MD,JAMES A, WICHITA
 WHITAKER MD,REN R, OBERLIN
 WHITE II MD,BENJAMIN E, EL DORADO
 WHITE MD,CHARLES F, WICHITA
 WHITE MD,CHARLES L, GREAT BEND
 WHITE MD,CHARLES M, WICHITA
 WHITE MD,DONALD C, COFFEYVILLE
 WHITE MD,FAGAN N, RUSSELL
 WHITE MD,JOHN P, SHAWNEE MISSION
 WHITE MD,KERMIT E, WICHITA
 WHITE MD,R BURNLEY, WINFIELD
 WHITEHEAD MD,RICHARD E, SHAWNEE MISSION
 WHITESIDE MD,WILLIAM H, WICHITA
 WHITLEY MD,DOUGLAS M, SHAWNEE MISSION
 WIEN MD,STEVEN M, SHAWNEE MISSION
 WIENS MD,J WENDELL, NEWTON
 WIENS,JONATHAN G, KANSAS CITY
 WIENS,LYNN A, KANSAS CITY,MO
 WIENS,TIMOTHY K, NEWTON
 WIGGINTON D.O., GERALD D, SHAWNEE MISSION
 WIGGLESWORTH MD,ANNE, WAMEGO
 WIKOFF MD,DONALD L, GREAT BEND
 WILCOX EXEC SEC, GENE M., WINFIELD
 WILCOX JR MD,HOWARD L, HAYS
 WILCOX SR MD,HOWARD L, LAWRENCE
 WILDER MD,LOWELL W, WICHITA
 WILDS MD,CHARLES E, BELLA VISTA,AR
 WILEY MD,JOHN H, SHAWNEE MISSION
 WILKINSON MD,LARRY K, WICHITA
 WILLARD EXEC SEC, JUDY, ELLINWOOD
 WILLIAMS MD,CHARLES L, WICHITA
 WILLIAMS MD,EVAN R, MESA,AZ
 WILLIAMS MD,FENTON A, KANSAS CITY
 WILLIAMS MD,HOMER J, LAGUNA NIGUEL,CA
 WILLIAMS MD,RONALD P, WICHITA
 WILLIAMS MD,THOMAS A, SHAWNEE MISSION
 WILLIAMS,CARL M, SHAWNEE MISSION
 WILLIAMS,MICHAEL K, KANSAS CITY
 WILLIAMS,NANCY J, KANSAS CITY
 WILLIAMS,TERI L, KANSAS CITY
 WILSON MD,DAVID B, KANSAS CITY
 WILSON MD,H RANDOLPH, HALSTEAD
 WILSON MD,J WELLS, WICHITA
 WILSON MD,JAMES W, COFFEYVILLE
 WILSON MD,MARVIN H, TOPEKA
 WILSON MD,ROBERT B, SHAWNEE MISSION
 WILSON MD,ROBERT L, VALLEY CENTER
 WILSON MD,SLOAN J, SHAWNEE MISSION
 WILSON,DANIEL R, VALLEY CENTER
 WILSON,LORI J, SHAWNEE MISSION
 WIN MD,AYE M, DODGE CITY
 WINBLAD MD,J KENT, WINFIELD
 WINBLAD MD,JAMES N, WINFIELD
 WINBLAD MD,JOHN M, WINFIELD
 WINCHESTER MD,EUGENE B, CORTEZ,CO
 WINEINGER,DAVID K, SHAWNEE MISSION
 WINGER MD,RAYMOND E, HUGOTON
 WINN MD,TERRIA L, WICHITA
 WISDOM MD,JAY K, SUN CITY,AZ
 WISNER JR MD,HARRY J, WICHITA
 WITTMAN MD,A T, PRATT
 WITTMANN MD,ALBERT F, WICHITA
 WOHLER MD,JOHN P, SAN ANTONIO,TX
 WOLF MD,KARL T, KANSAS CITY
 WOLF MD,PATRICK G, WICHITA
 WOLF MD,STEPHEN B, FORT SCOTT
 WOLFE MD,FREDERICK, WICHITA
 WOLFF MD,FREDERICK P, PRATT
 WOLKOFF MD,CDR A STARK, MAKAWAO,HA
 WOLLMANN MD,MARTIN, LAWRENCE
 WONG MD,CURTIS S F, WICHITA
 WONG MD,GEORGE F, KANSAS CITY
 WOOD MD,FRED M, SHAWNEE MISSION
 WOOD MD,GARY B, WICHITA
 WOOD MD,GARY L, ARKANSAS CITY

WOOD MD,ROBERT D, WICHITA
 WOODALL MD,DENNIS C, SALINA
 WOODHOUSE MD,CHARLES L, WICHITA
 WOODRING MD,CATHY S, WICHITA
 WOODROOF,JANET M, KANSAS CITY
 WOODS MD,GREGORY A, SHAWNEE MISSION
 WOODS MD,ROBERT P, TOPEKA
 WOODS,DENNIS D, SHAWNEE MISSION
 WOODS,MICHAEL S, WICHITA
 WORSING JR MD,ROBERT A, WICHITA
 WORTMAN MD,JACK A, HUTCHINSON
 WRAY JR MD,REGINALD P, WICHITA
 WRAY MD,ALEXANDER J, WICHITA
 WRIGHT MD,KENDALL M, EMPORIA
 WRIGHT MD,STANLEY E, JUNCTION CITY
 WRIGHT,CHRISTOPHER, KANSAS CITY
 WRIGHT,MICHAEL J, KANSAS CITY
 WRIGHT,TIMOTHY F, WICHITA
 WULFF MD,EDWIN T, ATCHISON
 WULZ,CURTIS E, KANSAS CITY
 WURSTER MD,GEORGE R, SHAWNEE MISSION
 WURSTER,SAMUEL H, KANSAS CITY
 WYATT-HARRIS MD,PATRICIA G, WICHITA

Y

YAGHMOUR MD,TALAA E, PITTSBURG
 YANG MD,GAN-HSIUNG, TOPEKA
 YE MD,RICHARD C, SHAWNEE MISSION
 YEH MD,ROBERT M, TOPEKA
 YEOMANS MD,RONALD N, SHAWNEE MISSION
 YOACHIM MD,ROBERT W, ARKANSAS CITY
 YOCKEY MD,CHARLES C, LAWRENCE
 YODER MD,EMERSON D, DENTON
 YODER MD,VERNON E, HESSTON
 YOHE MD,RUTH M, SHAWNEE MISSION
 YOON MD,CHANG SUP, WICHITA
 YORKE JR MD,CRAIG H, TOPEKA
 YOST JR MD,JOHN G, KANSAS CITY,MO
 YOUN MD,HWAN, GREAT BEND
 YOUNG MD,CHARLES H, ATCHISON
 YOUNG MD,DOUGLAS L, WICHITA
 YOUNG MD,JOHN W, SHAWNEE MISSION
 YOUNG MD,PAUL E, TOPEKA
 YOUNG MD,THEODORE E, TOPEKA
 YOUNG,JEFFREY L, SHAWNEE MISSION
 YOUNGBERG MD,DEAN I, WICHITA
 YULICH MD,JOHN O, SABETHA

Z

ZABEL MD,KENNETH P, PITTSBURG
 ZACHARIAS MD,CARL KURT, DODGE CITY
 ZACHARIAS MD,DAVID LLOYD, TOPEKA
 ZACK MD,ASHLEY S, SHAWNEE MISSION
 ZAINALI MD,ASSADOLLAH, LIBERAL
 ZAMIEROWSKI MD,DAVID S, SHAWNEE MISSION
 ZAREMSKI MD,SHERMAN C, KANSAS CITY
 ZARNOW MD,HILARY, WICHITA
 ZARR MD,JAMES S, KANSAS CITY,MO
 ZATZKIN MD,JAY B, WICHITA
 ZAUCHE MD,JAMES T, GARDEN CITY
 ZAYAS,VLADISLAV, MANHATTAN
 ZECHMANN,JEROME P, KANSAS CITY
 ZELLER MD,MYRON J, GARDEN CITY
 ZEPICK MD,LYLE F, WICHITA
 ZERBE MD,KATHRYN, TOPEKA
 ZIEGLER MD,JUDY P, WICHITA
 ZIEGLER MD,DEWEY K, KANSAS CITY
 ZIEGLER MD,JOHN M, WICHITA
 ZIELKE MD,STEVEN L, WICHITA
 ZIMBELMAN,ROD D, DENVER,CO
 ZIMMERMAN MD,KENNETH D, WICHITA
 ZIMMERMAN MD,WILLIAM H, TOPEKA
 ZINN MD,THOMAS W, KANSAS CITY
 ZOELLNER MD,TIMOTHY M, KANSAS CITY
 ZONGKER MD,PHILIP E, WICHITA
 ZURITA MD,MARCOS, GREAT BEND



Medical Specialty Codes Used in This Directory

A	Allergy	NM	Nuclear Medicine
ADL	Adolescent Medicine	NOTO	Neuro-otology
ADM	Administrative Medicine	NP	Neuropsychiatry
ADT	Addictionology	NR	Nuclear Radiology
AM	Aviation Medicine	NS	Neurological Surgery
ANES	Anesthesiology	OBG	Obstetrics and Gynecology
BLB	Blood Bank	OM	Occupational Medicine
CD	Cardiovascular Disease	ON	Oncology
CDS	Cardiovascular Surgery	OPH	Ophthalmology
CDTS	Cardiovascular & Thoracic Surgery	ORS	Orthopedic Surgery
CHP	Child Psychiatry	OTO	Otorhinolaryngology
CP	Clinical Pharmacology	P	Psychiatry
D	Dermatology	PATH	Pathology
DR	Diagnostic Roentgenology	PD	Pediatrics
EENT	Eye, Ear, Nose and Throat	PDA	Pediatric Allergy
EM	Emergency Medicine	PDC	Pediatric Cardiology
END	Endocrinology	PDE	Pediatric Endocrinology
ENT	Ear, Nose Throat	PDN	Pediatric Neurology
ES	Endoscopy Surgery	PNP	Pediatric Nephrology
FM	Family Medicine	PDO	Pediatric Ophthalmology
FP	Family Practice	PDS	Pediatric Surgery
GE	Gastroenterology	PGER	Psychogerontology
GP	General Practice	PH	Public Health
GPM	General Preventive Medicine	PM	Physical Medicine & Rehabilitation
GPVS	General & Peripheral Vascular Surgery	PS	Plastic Surgery
GS	General Surgery	PUD	Pulmonary Disease
GYN	Gynecology	R	Radiology
HEM	Hematology	RHU	Rheumatology
ID	Infectious Diseases	RM	Rehabilitative Medicine
IE	Insurance Examination	RO	Radiology/Oncology
IM	Internal Medicine	RT	Radiation Therapy
MFM	Maternal Fetal Medicine	SON	Surgical Oncology
N	Neurology	TR	Therapeutic Radiology
NEO	Neonatology	TS	Thoracic Surgery
NEP	Nephrology	U	Urology
		00	Retired



Physician Distribution by Cities

EXPLANATION OF CODES USED IN THIS SECTION

Line 1: Doe, John R., 1234 Oak St., 67052
(Name) (Street Address) (Zip Code)

Line 2: (654-2222)
(Telephone Number)

Line 3: 33 M 1902 58 FP
(Year of Birth) (Sex) (Medical School) (Year of Licensure) (Specialty)

Telephone area code follows city name. * Probationary Members

ABILENE — 913 (Dickinson County Medical Society)

BERKLEY MD,DON H, 1111 N BRADY, 67410
 263-4131
 35 M 1902 62 FP

CHAFFEE MD,DEAN C, RR 1, 67410
 11 M 1902 44 OO

COLEMAN MD,GARY, 1405 N CEDAR, 67410
 263-7190
 46 M 1902 73 FP

MOHLER MD,JACK M, 420 NE TENTH, 67410
 263-1419
 32 M 1902 62 PM

NARCISO MD,VICENTE D, 515 NE 10TH ST, 67410
 263-2253
 45 M 74810 76 GS

RORABAUGH MD,DONALD C, PROFESSIONAL BLDG 1111 BRADY, 67410
 263-4131
 33 M 1902 59 FP

SHEERN MD,MARK DOUGLAS, 1111 N BRADY, 67410
 263-4131
 51 M 1902 77 FP

SONGER MD,HERBERT L, 1007 SPRUCEWAY, 67410
 12 M 1902 38 OO

ALMA — 913 (Pottawatomie County Medical Society)

MCKNIGHT MD,ELLIS B, , 66401
 03 M 1902 33 OO

ALTAMONT — 316 (Labette County Medical Society)

JACKSON MD,VICTOR L, BOX 467, 67330
 20 M 2105 54 OO

ANDALE — 316 (Sedgwick County Medical Society)

HUFFORD MD,DAVID W, PO BOX 38, 67001
 262-1654
 58 M 1902 85 FP

STECH MD,JOSEPH M, PO BOX 38, 67001
 445-2152
 27 M 3006 57 FP

ANDOVER — 316 (Sedgwick County Medical Society)

BEECH MD,RANDALL R, 310 W CENTRAL, 67002
 733-1331
 54 M 1902 81 GS

LEMONS MD,STEPHEN F, 310 W CENTRAL, 67002
 733-1331
 54 M 1902 83 FP

ANTHONY — 316

ANTRIM MD,PHILIP JENIFER, BOX 84 RT 1, 67003
 15 M 1902 42 OO

MILLER MD,PHILIP, PO BOX 410, 67003
 842-5144
 44 M 1902 GS

ARKANSAS CITY — 316 (Cowley County Medical Society)

AUCAR MD,ALFREDO, BOX 1105, 67005
 442-1710
 23 M 27501 70 OTO

CAMPBELL MD,GARLAND L, ROUTE 1, 67005
 13 M 1902 40 OO

HILL MD,JAMES E, 1019 N SECOND, 67005
 09 M 1902 34 OO

HINSHAW MD,EDGAR D, RT 4 BOX 74, 67005
 15 M 1902 51 OO

HOLLIS MD, KENNETH W, 114 W WALNUT, 67005
442-0163
54 M 1902 GS

MARVEL MD, JAMES EBBERT, 2545 N GREENWAY, 67005
442-0222
43 M 3901 72 ORS

MORTON MD, ROBERT A, AC OFFICE BLDG, 67005
442-0370
51 M 1902 80 IM

OLD MD, JERRY L, PO BOX 1148, 67005
442-2100
49 M 1902 75 FP

PEREIRA MD, WILLY G, 2508 EDMONT DR, 67005
442-8540
39 M 73701 73 IM

ROSS MD, DAVID K, PO BOX 1148, 67005
442-2100
48 M 1902 75 FP

SCHMEIDLER MD, DAVID ALLEN, 510 W RADIO LANE, 67005
442-2100
54 M 1902 82 FP

SMITH MD, BRUCE G, P O BOX 714, 67005
442-5600
20 M 1902 44 OO

SMITH MD, NEWTON C, PO BOX 1148, 67005
442-2100
21 M 3901 51 FP

WOOD MD, GARY L, 401 N SUMMIT, 67005
442-0103
52 M 64936 83 R

YOACHIM MD, ROBERT W, 510 W RADIO LANE, 67005
442-2100
52 M 3005 80 FP

ATCHISON — 913 *(Atchison County Medical Society)*

BOSSE MD, FRANK K, 1301 RIVERVIEW DR, 66002
09 M 2802 36 OO

BURKE MD, JOSEPH V, 1400 N SECOND, 66002
367-5496
35 M 3006 71 GS

EPLEE MD, JOHN R, 1225 N SECOND, 66002
367-0362
53 M 1902 82 FP

FAST MD, ROBERT E, 1225 N 2ND, 66002
367-0362
48 M 1902 75 OBG

FAST MD, W SPENCER, 1301 N SECOND, 66002
367-7417
11 M 3006 40 FP

GROWNEY MD, JOHN T, 801 ATCHISON, 66002
367-5020
37 M 3006 66 FP

HART MD, LAWRENCE E, 1412 N 2ND, 66002
367-5054
32 M 1902 65 FP

JONES MD, MICHAEL P, 1225 N 2ND, 66002
367-0362
55 M 1902 85 FP

MORRISON MD, IRA R, 825 N TENTH, 66002
07 M 1611 38 OO

RIDER MD, JAMES W, 1225 N 2ND ST, 66002
367-0362
47 M 2803 76 FP

TAYIEM MD, A K, 1225 N SECOND, 66002
367-1114
43 M 33002 72 GS

TIVORSAK MD, ARKOM, PO BOX 127, 66002
367-2131
40 M 89101 76 R

VESOM MD, PITT, PO BOX 328, 66002
367-3100
49 M 89104 83 CD

WALLACE JR MD, WAYNE O, 1301 N THIRD, 66002
367-7300
36 M 2803 67 FP

WULFF MD, EDWIN T, 923 N FIFTH, 66002
367-5033
07 M 2834 36 OO

YOUNG MD, CHARLES H, 1301 N 3RD, 66002
367-4053
23 M 1902 53 FP

ATTICA — 316

STONE MD, GRANT C, 500 N HARPER, 67009
254-7219
08 M 5605 69 FP

ATWOOD — 913 *(Northwest Kansas Medical Society)*

DILL MD, RODNEY, 411 PAGE, 67730
626-3229
41 M 74811 78 GP

AUGUSTA — 316 *(Butler-Greenwood County Medical Society)*

ANDERSON MD, DALE W, 120 W JOSEPHINE, 67010
775-5432
30 M 1902 55 FP

BARBER MD, JAMES L, 120 W JOSEPHINE, 67010
775-5432
31 M 1902 57 FP

FANNING MD, JANET L, 602 STATE, 67010
775-1186
57 F 1902 84 FP

FANNING MD, KYLE W, 602 STATE, 67010
775-1186
56 M 1902 84 FP

TRAN MD, TUONG M, 120 W JOSEPHINE, 67010
775-5432
39 M 94101 77 FP

BASEHOR — 913 *(Wyandotte County Medical Society)*

BURGER MD, WILLIAM E, RT 1, 66007
21 M 3006 51 OO

BAXTER SPRINGS — 316 *(Crawford-Cherokee County Medical Society)*

ALQUIST MD, VERYL D, 21ST & FAIRVIEW, 66713
17 M 1902 42 OO

BELLEVILLE — 913 *(Republic County Medical Society)*

DOUBEK MD, HERBERT D, PO BOX 250, 66935
527-2237
28 M 1902 56 FP

WARD MD, JAMES A, 1206 18TH ST, 66935
527-2217
34 M 1902 59 FP

BELOIT — 913
(Mitchell County Medical Society)

DOBRATZ MD, ROBERT A, 310 W 8TH, 67420
738-2246
24 M 1902 52 FP

DRAKE MD, DOUGLAS J, MEDICAL CENTER, 67420
738-2246
43 M 1902 72 FP

KLEND JR MD, MARTIN B, BELOIT MED CTR 310 W 8TH, 67420
738-2246
38 M 1643 66 GS

WELTMER MD, ROGER P, 112 W MAIN, 67420
18 M 1902 44 OO

BLUE RAPIDS — 913
(Northeast Kansas Medical Society)

LAWLESS MD, HAROLD L, PO BOX 127, 66411
226-7202
29 M 702 58 FP

BONNER SPRINGS — 913
(Wyandotte County Medical Society)

MAY MD, KENNETH L, 525 MACGRANTWOOD DR, 66012
422-2020
20 M 1902 41 FP

MITTS MD, ERNEST W, 122 N NETTLETON, 66012
422-2020
22 M 1902 51 FP

BUHLER — 316
(Reno County Medical Society)

FRIESEN MD, ORLANDO J, 107 W 2ND, 67522
543-2330
27 M 1902 56 FP

BURLINGTON — 316
(Flint Hills Medical Society)

FRIESEN MD, ORLANDO J, RR #1 BOX 395, 66839
347-8619
27 M 1902 56 FP

CANEY — 316
(Southeast Kansas Medical Society)

MOORE MD, ROBERT F, 4TH & MCGEE, 67333
879-2135
28 M 1902 56 FP

CHANUTE — 316
(Southeast Kansas Medical Society)

ABBUEHL MD, DON R, 932 WINDSOR, 66720
18 M 1902 44 OO

ASHLEY MD, SAMUEL G, 505 SOUTH PLUMMER, 66720
431-2500
16 M 1902 43 OO

BAKER MD, HENRY K, 1220 W FOURTH, 66720
08 M 1606 52 OO

BURKMAN MD, REUBEN J, 1501 W 7TH, 66720
431-9310
28 M 1902 54 FP

GEHRT MD, EARL B, 505 S PLUMMER, 66720
431-2500
32 M 1902 63 FP

KIHM MD, ALBERT A, 505 S PLUMMER, 66720
431-2500
27 M 1902 55 FP

MABEN MD, PAMELA S, 505 S PLUMMER, 66720
431-2500
54 F 1902 80 IM

MC FARLAND MD, GRETA S, 505 S PLUMMER, 66720
431-2500
54 F 1902 81 PD

MIH MD, ALEXANDER, 1002 WEST 4TH, 66720
473-2227
22 M 24209 72 ANES

PARHAM MD, VERDON W, 505 S PLUMMER, 66720
431-2500
47 M 1902 75 FP

VAN HOUDEN MD, CHARLES E, 505 S PLUMMER, 66720
431-2500
52 M 1902 77 GS

CHAPMAN — 913
(Dickinson County Medical Society)

SVOBODA MD, CHARLES R, 225 W 9TH, 67431
18 M 1902 46 OO

CHETOPA — 316
(Labette County Medical Society)

PEFFLY MD, ELMER D, 327 MAPLE, 67336
236-7188
22 M 3901 56 FP

CLAY CENTER — 913
(Clay County Medical Society)

ANDERSON MD, SEVERT A, 1749 BERGLUND DR, 67432
07 M 1902 36 OO

BROWNING MD, JIMMIE L, 709 LIBERTY BOX 520, 67432
632-2181
50 M 1902 79 FP

BRYANT MD, R KEVIN, PO BOX 520, 67432
632-2181
54 M 515 81 FP

DALUM MD, PETER JOSEPH, PO BOX 520, 67432
632-2181
45 M 2803 77 FP

GOOD MD, MICHAEL W, PO BOX 520, 67432
632-2181
53 M 1902 81 FP

HATESOHL, STANLEY M, 709 LIBERTY, 67432
632-2181
57 M 1902 FP

RICHARDS MD, DENNIS D, 115 S 6TH, 67432
632-5621
34 M 1902 61 FP

CLYDE — 913
(Cloud County Medical Society)

COULTER D.O. MD, THAYNE A, 306 N HIGH, 66938
12 M 2878 37 OO
FREEBORN JR MD, WARREN S, , 66938
446-2221
26 M 1720 60 FP

COFFEYVILLE — 316
(Southwest Kansas Medical Society)

BLOCK MD, JEROME E, PO BOX 464, 67337
251-2400
38 M 3305 IM
CAMPBELL MD, WILLIAM H, 1411 W 4TH STE D, 67337
251-3235
39 M 1902 66 OPH
CANTWELL MD, MICHAEL L, 209 W 7TH, 67337
251-4901
56 M 1902 P
DICKINSON MD, CHARLES R, 608 SPRUCE, 67337
20 M 1606 47 OO
DIXON MD, RAYMOND W, 1411 W 4TH STE E, 67337
251-1090
46 M 4706 77 GS
GIBBS MD, EUGENE, PO BOX 716, 67337
251-7260
00 M 64914 72 FP
HAN MD, CHAN S, 908 SIGGINS, 67337
251-1560
35 M 58306 74 PD
HOWERTER JR MD, BERNARD E, PO BOX 659, 67337
251-4790
43 M 1803 73 U
READ MD, WILLIAM T, 807 MAPLE, 67337
251-1120
16 M 2802 46 FP
REID MD, DONALD A, RTE 1 BOX 285J, 67337
251-3217
35 M 3901 ANES
UY MD, WILSON O, COFFEYVILLE MEM HOSP 101 TYLER, 67337
251-1200
42 M 74801 73 PATH
WHITE MD, DONALD C, PO BOX 1449, 67337
251-1200
35 M 3515 72 R
WILSON MD, JAMES W, 1802 W 4TH PO BOX 469, 67337
251-5210
26 M 3901 GP

COLBY — 913
(Northwest Kansas Medical Society)

DAHL MD, ASHER W, 175 S RANGE, 67701
462-3333
28 M 1902 59 FP
FITZGERALD MD, E JAMES, 175 S RANGE, 67701
462-3332
00 M IM
HASSETT MD, GERARD R, 1875 HARVEY, 67701
462-6492
24 M 3006 61 R

HILDYARD II MD, VICTOR H, 175 S RANGE, 67701
462-3332
47 M 702 74 FP
KOLSTE MD, REX J, 310 E COLLEGE, 67701
462-3332
53 M 3005 83 FP
REGIER MD, LADONNA M, 175 S RANGE, 67701
462-3332
47 F 1902 74 FP
SMITH JR MD, FLOYD L, 880 SUNSET, 67701
20 M 1902 44 OO

COLDWATER — 316
(Iroquois County Medical Society)

GOERING MD, DONALD D, BOX 748, 67029
582-2136
31 M 1902 56 FP

COLUMBUS — 316
(Crawford-Cherokee County Medical Society)

JONES MD, FORREST H, 219 S KANSAS, 66725
429-3744
25 M 1902 54 FP
RICHMAN MD, DANA R, 301 N KANSAS, 66725
429-3636
54 M 1902 FP
RICHMAN MD, DAVID S, 1108 E MAPLE, 66725
429-3636
57 M 1902 85 FP

CONCORDIA — 913
(Cloud County Medical Society)

BRAY MD, AVIS PAGE, 1010 3RD, 66901
17 F 702 60 OO
CORNELL MD, EARL G, BOX 589, 66901
243-1560
54 M 1902 83 FP
FOWLER MD, WAYNE L, 1010 THIRD PO BOX 589, 66901
243-1560
23 M 1720 53 IM
LAWTON MD, MARVIN K, 1010 THIRD PO BOX 589, 66901
243-1560
31 M 3005 66 GS
NEWMAN MD, CARL T, PO BOX 587, 66901
243-2511
49 M 64914 78 U
RUZICKA MD, LAWRENCE J, 1115 HILLSIDE, 66901
243-1560
13 M 3005 46 OO
STRYKER JR MD, HENRY B, 717 FIRST, 66901
19 M 3501 52 OO
THORNTON JR MD, FOXHALL P, 723 W 7TH, 66901
243-1560
25 M 5101 55 IM

COUNCIL GROVE — 316
(Flint Hills Medical Society)

BLACKBURN MD, ROBERT W, 221 HOCKADAY, 66846
767-5126
22 M 1902 49 FP
SCHULTZ MD, JAMES E, 221 HOCKADAY, 66846
767-5126
26 M 1902 56 FP

CUNNINGHAM — 316 (Ninnescah Medical Society)

ALLBRITTEN JR MD, FRANK F, PO BOX 177, 67035
298-2542
14 M 4101 54 GS

DENTON — 913 (Northeast Kansas Medical Society)

YODER MD, EMERSON D, , 66017
359-6531
14 M 1902 49 FP

DERBY — 316 (Sedgwick County Medical Society)

MCKERRACHER MD, ROBERT D, 400 A NORTH BALTIMORE, 67037
788-1779
27 M 3901 56 FP

MILLER MD, ROGER M, 5901 S GREENWICH RD, 67037
788-6270
37 M 4102 83 BLB

NIEDEREE MD, DAVID W, 1410 N WOODLAWN, 67037
788-3741
56 M 3006 84 FP

SAEED MD, MOHAMMAD, 615 B N ROCK RD, 67037
788-5754
42 M 70404 81 EM

VIN ZANT MD, LARRY E, 1410 N WOODLAWN, 67037
682-6532
10 M 1902 40 OO

VINZANT MD, MARK N, 1410 N WOODLAWN, 67037
788-3741
45 M 64914 77 FP

DIGHTON — 316 (Southwest Kansas Medical Society)

VON LEONROD JR MD, GEORGE, PO BOX 146, 67839
397-5314
16 M 1902 43 FP

DODGE CITY — 316 (Ford County Medical Society)

AMAWI MD, MOHAMMAD S, 2020 CENTRAL, 67801
225-1371
46 M 87501 76 GS

AVILA MD, OSCAR A, 2020 CENTRAL, 67801
225-1371
41 M 17603 75 IM

AYUTHIA MD, ISSARA I, 2004 FREDERICK DR, 67801
40 M 89101 78 PATH

BOLES MD, R DALE, 2020 CENTRAL, 67801
225-1371
23 M 3901 54 PD

CHOTIMONGKOL MD, ANUPONG, 2020 CENTRAL, 67801
225-1371
43 M 89102 76 OBG

CONANT MD, MERRILL, 120 ROSS, 67801
227-6550
00 M FP

CONARD MD, CLAIR C, 2020 CENTRAL, 67801
225-1371
27 M 1902 55 IM

GARCIA MD, GUILLERMO O, 1206 FRONTVIEW, 67801
225-7710
43 M 23101 77 ORS

GREENBERG MD, GEORGE E, 1904 BURR PKWY, 67801
225-1033
42 M 401 72 R

JOHNSON MD, HOWELL D, 2020 CENTRAL, 67801
225-1371
45 M 1902 72 IM

KROGH MD, STEVE, 900 MARSHA LN, 67801
225-1371
00 M FP

KYI MD, WIN M, SOUTHWEST CL 806 SECOND, 67801
227-3141
49 M 20901 GS

MARPLES MD, DOUGLAS, 2020 CENTRAL, 67801
225-1371
00 M 1902 IM

MCCOY MD, RONALD, SOUTHWEST CL 806 2ND AVE, 67801
227-3141
19 M 3901 49 FP

MCELHINNEY MD, CHARLES F, 2020 CENTRAL, 67801
225-1371
36 M 1902 63 GS

NIXON MD, JAMES E, 925 CLUB VIEW DR, 67801
225-1033
40 M 4812 79 DR

OHMAN MD, RICHARD J, 1810 1/2 FAIRWAY DR, 67801
15 M 2407 50 OO

REDDY MD, SATTI S, 2020 CENTRAL, 67801
225-1371
35 M 49504 77 U

SACHDEVA MD, REKHA, SOUTHWEST CL PO BOX 1517, 67801
225-7930
00 M PD

SCHWARTZ MD, EUGENE W, 2100 CAROUSEL, 67801
24 M 1902 50 OO

STOCKWELL MD, MORGAN U, 2020 CENTRAL PO BOX 1000, 67801
225-1371
24 M 1902 55 IM

TREKELL MD, WILLIAM V, SOUTHWEST CL 806 SECOND, 67801
227-3141
25 M 1902 52 ORS

TROTTER MD, ROGER COURTNEY, 120 ROSS BLVD, 67801
225-6120
47 M 1902 76 FP

VIERTHALER MD, CARL A, 2020 CENTRAL, 67801
225-1371
53 M 1902 78 IM

VIERTHALER MD, STEPHEN L, 2020 N CENTRAL BOX 1000, 67801
225-1371
00 M 78 OBG

WIN MD, AYE M, SOUTHWEST CL 806 SECOND, 67801
227-3141
50 M 20901 IM

ZACHARIAS MD, CARL KURT, 2020 CENTRAL, 67801
225-1371
21 M 40707 59 ORS

EL DORADO — 316
(Butler-Greenwood County Medical Society)

AHMAD MD, ABDU Q, 720 W CENTRAL, 67042
321-7402
32 M 16002 84 OTO

BRIAN MD, ROBERT M, 1133 W FIRST, 67042
02 M 1606 31 OO

DELLETT MD, KENNETH B, 3RD & VINE, 67042
321-1910
30 M 1902 55 OPH

HAFFNER MD, WILLIAM N, 123 N ATCHISON, 67042
321-5630
35 M 1902 62 GS

JACOB MD, KANNAMPALLY L, 123 N ATCHISON, 67042
321-0056
31 M 49537 76 U

KASSEBAUM MD, GLEN E, RR #2 BOX 19, 67042
98 M 1606 24 OO

LEE MD, YONG U, 123 N ATCHISON, 67042
321-5630
35 M 58310 77 GS

OLSEN MD, PHILLIP S, 123 N ATCHISON, 67042
321-2100
46 M 1902 73 IM

OVERHOLSER MD, NORMAN H, 119 N JONES, 67042
321-2010
16 M 1902 41 FP

PATRON MD, RICARDO A, 123 N ATCHISON, 67042
321-7596
31 M 74808 83 OBG

REDDY MD, VENUMBAKA C, 123 ATCHISON ROOM 302, 67042
321-3300
46 M 49511 79 IM

SHIELDS JR MD, JAMES M, 119 N JONES, 67042
321-2010
18 M 4802 46 FP

SIWEK MD, CHRISTOPHER W, 123 N ATCHISON STE 303, 67042
321-5211
48 M 75911 78 ORS

WHITE II MD, BENJAMIN E, 119 N JONES, 67042
321-2010
27 M 1902 54 FP

ELKHART — 316
(Seward County Medical Society)

IWAY MD, BELINO D, 411 SUNSET BOX 878, 67950
697-2175
42 M 74811 78 IM

IWAY MD, OLIVIA N, PO BOX 878, 67950
697-2175
43 F 74811 80 P

PERIDO MD, DOMINADOR T, BOX 997, 67950
697-2155
44 M 74801 75 GS

ELLINWOOD — 316
(Barton County Medical Society)

LAW MD, FINDLEY, PO BOX 668, 67526
564-2170
22 M 1902 51 FP

WILLARD EXEC SEC, JUDY, BARTON COUNTY MED SOCIETY, 67526
792-4391
00 F

ELLSWORTH — 913
(Central Kansas Medical Society)

DEES MD, DANIEL J, 308 KINGSLEY, 67439
472-3121
55 M 1902 81 FP

SEITZ JR MD, JOSEPH E, 308 KINGSLEY, 67439
22 M 1902 46 OO

EMPORIA — 316
(Flint Hills Medical Society)

AMEND MD, DOUGLAS J, 827 COMMERCIAL, 66801
343-6565
46 M 1902 79 OBG

BARNETT MD, JAMES A, 919 W 12TH, 66801
342-2521
54 M 1902 82 IM

BOSILJEVAC JR MD, JOSEPH E, 2522 W 15TH, 66801
343-7043
51 M 1902 81 TS

BRADLEY MD, H RUSSELL, 1601 STATE, 66801
343-2900
35 M 1902 62 FP

BROCKHOUSE MD, JOHN P, 1601 STATE, 66801
343-2900
31 M 1902 57 IM

BURGESON MD, FRANK G, 1601 STATE, 66801
342-6989
40 M 3005 71 OPH

BUTCHER MD, THOMAS P, 2029 HUNTINGTON RD, 66801
05 M 1601 34 OO

CAMPBELL MD, EDWARD G, 1601 STATE, 66801
343-2900
31 M 1902 62 FP

DAVIS MD, DAVID R, 2300 INDUSTRIAL RD #108, 66801
02 M 2101 28 OO

DICK JR MD, HENRY J, 25 W 5TH, 66801
342-2341
27 M 1902 59 FP

EDWARDS MD, DAVID J, 1601 STATE, 66801
343-1191
43 M 2803 77 ORS

ELLIS MD, BOBBY J, 1601 STATE, 66801
343-2900
51 M 1902 78 IM

FARRIS MD, RONNIE S, 1601 STATE, 66801
343-2900
50 M 3840 81 GS

GANN MD, E LAMONTE, RR #2, 66801
07 M 2802 44 OO

GARCIA MD, GOULD C, 919 W 12TH, 66801
342-2521
32 M 3607 65 IM

GEITZ MD, JAMES M, 919 W 12TH, 66801
342-2521
46 M 1902 73 IM

GINAVAN MD, DUANE A, 1024 W 12TH, 66801
342-5876
35 M 1902 63 FP

GLENN MD, JAMES N, 1601 STATE, 66801
343-1191
40 M 4804 70 ORS

HARVEY MD, JOHN E, 2506 W 15TH, 66801
343-7650
39 M 1902 77 OBG

HAVENHILL II MD,MARSHALL A, 812 ANDERSON ST, 66801
343-6400

35 M 1902 62 OBG

HOPPER MD,CHARLES R, 1726 OLD MANOR RE, 66801

17 M 1902 47 OO

HOWELL MD,BARBARA JOYCE, 1601 STATE, 66801

343-2900

45 F 3401 82 PD

KNECHT MD,STEPHEN M, NEWMAN HOSP 12TH & CHESTNUT, 66801

342-7722

44 M 1902 72 R

KRETSINGER DO ,W BROCK, 919 WEST 12TH, 66801

342-2521

48 M 2878 81 IM

KUMAR MD,RENU, 1601 STATE, 66801

342-5881

55 F 49610 82 PD

LLOYD MD,JOHN C, 827 COMMERCIAL, 66801

343-6565

50 M 4814 86 OBG

MIGUELINO MD,OLIVER M, C/O NEWMAN MEM HOSPITAL, 66801

343-6800

35 M 74801 71 PATH

MONTGOMERY MD,MICHAEL L, 1601 STATE, 66801

343-1191

53 M 1902 86 ORS

MORGAN MD,JOHN L, 1710 YUCCA LANE, 66801

15 M 4101 42 OO

NAGARAJU MD,ARRAMRAJU, NEWMAN MEM HOSP 12 & CHESTNUT, 66801

343-6800

48 M 49521 84 P

NAGARAJU MD,ARRAMRAJU, 827 COMMERCIAL ST, 66801

343-6565

48 M 49521 84 P

NEUER MD,FREDERICK S, 12TH & CHESTNUT, 66801

342-7722

46 M 3601 74 R

PASTOR MD,VICTOR HUGO, 1601 STATE STE 101, 66801

342-7715

43 M 13202 78 U

PIERSON MD,MARK E, 1024 W 12TH, 66801

343-6864

50 M 1902 82 FP

SCHELLINGER MD,RICHARD P, 1128 LAWRENCE, 66801

342-0722

22 M 3005 56 GS

SNOWBARGER MD,MARVIN D, 1601 STATE, 66801

343-2900

29 M 1902 55 FP

SPEARS MD,CHESTER A, NEWMAN HOSP 12TH & CHESTNUT, 66801

343-6800

50 M 2834 81 PATH

STEEVES MD,JOHN H, 1225 W 6TH, 66801

343-1065

32 M 6701 R

STONE MD,CHESTER W, 1601 STATE, 66801

343-2900

53 M 1902 85 HEM

TRIMBLE SR MD,DAVID P, 1703 SHERWOODWAY, 66801

342-2572

04 M 1902 32 OPH

UNDERWOOD MD,CHARLES C, 25 WEST 5TH, 66801

342-2341

07 M 1902 32 IM

VANDER VELDE MD,STANLEY LEROY, 1601 STATE, 66801

16 M 1902 43 OO

WRIGHT MD,KENDALL M, 1024 WEST 12TH, 66801

343-2376

45 M 1902 72 FP

ERIE — 316

(Southeast Kansas Medical Society)

BRYAN MD,EMERY C, RT 2 BOX 171, 66733

04 M 1902 32 OO

HANDSHY MD,STANLEY E, PO BOX 256, 66733

244-3291

54 M 1902 82 FP

ESKRIDGE — 913

(Flint Hills County Medical Society)

WALKER MD,WILLIAM H, 2ND & CEDAR BOX 218, 66423

10 M 2401 40 OO

EUDORA — 913

(Douglas County Medical Society)

HOLLADAY MD,KENNETH R, PO BOX G, 66025

542-2345

34 M 1902 61 FP

EUREKA — 316

(Butler-Greenwood County Medical Society)

CISKEY MD,WILLIAM J, PO BOX 310, 67045

583-7401

47 M 1902 74 FP

SKAER MD,STANLEY ALLEN, 100 E 16TH, 67045

583-7486

40 M 3901 78 GS

FALL RIVER — 316

(Sedgwick County Medical Society)

CARTER MD,MACK A, RR 1 #9, 67047

18 M 1902 50 OO

FORT SCOTT — 316

(Bourbon County Medical Society)

AKERS MD,GUY I, 618 MEADOW LN, 66701

223-3100

20 M 1902 53 FP

ALDIS MD,HENRY, 501 S MAIN, 66701

223-3100

13 M 1902 41 OBG

ALDIS MD,WILLIAM, 1123 S CRAWFORD, 66701

20 M 1902 44 OO

BASHAM MD,JAMES J, 702 MEADOW LN, 66701

14 M 1902 37 OO

BENAGE MD,JOHN F, 821 BURKE, 66701

223-2200

32 M 1902 59 OBG

BRAUN MD,EDWARD W, 710 WEST 8TH, 66701

223-3100

42 M 1902 69 U

BURKE MD,JAMES J, 710 W 8TH, 66701

223-3100

35 M 2834 67 IM

CHOW MD,STANLEY Y, 1410 S EDDY, 66701
223-2200
18 M 24222 63 OO

DUNLAP MD,PATRICK S, 710 W 8TH, 66701
223-3100
53 M 3007 79 OBG

DUNSHEE MD,CARLYLE M, 710 W 8TH, 66701
223-3100
32 M 1902 57 GS

DUNSHEE MD,CHERYL A, 710 W 8TH, 66701
223-3100
54 F 1902 82 IM

GETTLER MD,DEAN T, 710 W 8TH, 66701
223-3100
31 M 1902 57 GS

GOOD MD,JAMES T, RR 1 BOX 140, 66701
21 M 2802 62 OO

GRANTHAM MD,HERBERT G, 710 W EIGHTH, 66701
223-2200
49 M 4501 84 PATH

GRIMALDI MD,GARY A, 710 W EIGHTH, 66701
223-3100
49 M 1902 76 OBG

GRIMALDI MD,KENNETH J, 710 W 8TH, 66701
223-3100
56 M 1902 PD

IRBY MD,PRATT, 124 S CRAWFORD, 66701
13 M 4705 40 OO

KERR MD,GERALD F, RR 5, 66701
223-6164
44 M 1902 PATH

MCCANN MD,PATRICK E, 710 WEST 8TH, 66701
223-3100
28 M 1902 60 IM

MCKENNA MD,MICHAEL J, 323 S JUDSON STE 120, 66701
223-3950
38 M 1902 65 FP

NELSON MD,T EUGENE, 710 W 8TH, 66701
223-3100
41 M 1902 69 FP

NICHOLS MD,ROBERT R, 902 HORTON, 66701
223-4100
50 M 2803 77 FM

PARRIS MD,ROGER D, 902 S HORTON, 66701
223-4100
51 M 2803 FP

PHELPS MD,DAVID WAYNE, 902 HORTON, 66701
223-4100
51 M 1902 77 FP

RADOM MD,SANFORD B, RT 1 BOX 205B, 66701
223-6029
40 M 1642 83 R

REEVES MD,C STEWART, 710 W 8TH, 66701
223-3100
37 M 1902 71 IM

SPENCER MD,JOHN HAROLD, 902 S HORTON, 66701
223-3100
47 M 1902 76 FP

THORNTON MD,JAMES L, 710 W EIGHTH, 66701
223-3100
55 M 1902 83 PD

WEDDLE MD,DOUGLAS P, 902 S HORTON, 66701
223-3100
43 M 1720 73 FP

WOLF MD,STEPHEN B, 323 S JUDSON, 66701
223-3950
51 M 1902 PD

FREDONIA — 316 (Southeast Kansas Medical Society)

BACANI MD,OSWALDO, PO BOX 576, 66736
378-3700
44 M 74810 78 GS

BAYLES MD,HUGH G, PO BOX 30, 66736
25 M 1902 52 OO

BEAL MD,RAYMOND J, 310 S 15TH, 66736
12 M 1902 38 OO

RINDT MD,PHILLIP L, 432 N SEVENTH, 66736
378-3341
45 M 1902 81 FP

SUMNER MD,RALPH N, PO BOX 537, 66736
378-2311
31 M 1902 57 FP

GARDEN CITY — 316 (Southwest Kansas Medical Society)

ARROYO MD,ZEFERINO, 2124 ANTLER RIDGE DR, 67846
275-3700
00 M 74802 75 GS

AUSTIN MD,JOHN O, 1810 OROSCO PL, 67846
14 M 1601 46 FP

BEGGS MD,DAVID F, 603 N FIFTH, 67846
275-3700
39 M 1902 65 IM

BIGLER MD,F CALVIN, 801 N FIFTH, 67846
275-2141
31 M 801 66 GS

BRUNO MD,JAMES W, 1133 KANSAS PLAZA, 67846
276-8201
42 M 4706 73 FP

CALBECK MD,JOHN, 603 N FIFTH, 67846
275-3700
50 M 1902 78 IM

COLLINS MD,SHARON A, 603 N FIFTH, 67846
275-3700
51 F 2512 81 PD

EICHHORN MD,FRANK D, BOX 719, 67846
276-8132
25 M 1902 56 FP

FENTON MD,ROBERT M, 603 N FIFTH, 67846
275-3700
20 M 1902 54 FP

FRY MD,LUTHER L, ST CATHERINE HOSP BOX 1928, 67846
275-7248
41 M 1902 68 OPH

GILBERT II MD,JOHN H, 603 N FIFTH, 67846
275-3700
46 M 1902 72 ORS

GREENWOOD MD,JAMES F, PO BOX 419, 67846
275-3700
33 M 1611 67 FP

HANSEN MD,FRANK W, 603 N FIFTH, 67846
275-3700
49 M 1902 78 PM

HUNSBERGER D.O.,TERRY R, 602 N THIRD, 67846
275-7128
47 M 2878 74 FP

KOKSAL MD,TOM, 1133 E KANSAS, 67846
276-8201
00 M 1902 77 FP

LE MD,CHUONG DUC, 912 N 5TH, 67846
275-4486
48 M 94101 83 GP

MATTHEWS D.O.,GEORGE E, 603 N FIFTH, 67846
275-3790
48 M 2878 83 OBG

MELIN MD,BRUCE D, 608 N FIFTH, 67846
275-6111
51 M 5605 82 PATH

MEYERS MD,STEPHEN, 603 N FIFTH, 67846
275-3700
48 M 2834 77 PD

MILLER MD,ROBERT E, 603 N FIFTH, 67846
275-3700
26 M 4812 75 GS

MORTON MD,JOHN E, 1505 E SPRUCE, 67846
99 M 35211 60 OO

RODRIGUEZ MD,PAUL L, BOX 1729, 67846
275-6111
39 M 4706 71 R

SNORTUM MD,ROBERT A, 603 N FIFTH, 67846
275-3700
52 M 2604 86 FP

SPIKES MD,MARION E, 603 N 5TH, 67846
275-9444
26 M 1902 63 OO

TEARE MD,MAX E, 1007 DAVIS, 67846
276-7689
28 M 1902 54 P

TRIOLO MD,PETER A, 610 N 6TH, 67846
275-7445
43 M 64933 82 DR

TURNER MD,JOHN W, 806 E THOMPSON, 67846
276-3292
13 M 1902 39 FP

VACHAL MD,EVA, 608 N FIFTH, 67846
275-6111
00 F 1902 77 PATH

WELCH MD,LAUREN A, 508 N 7TH, 67846
275-6111
45 M 1902 72 GS

ZAUCHE MD,JAMES T, 603 N FIFTH, 67846
275-3730
53 M 2604 86 PD

ZELLER MD,MYRON J, 603 N FIFTH, 67846
275-3700
38 M 1902 65 OM

GARDEN PLAIN — 316 *(Sedgwick County Medical Society)*

LIND II MD,EDWARD J, 728 BIERMANN, 67050
535-2218
53 M 1902 79 FP

REINHARDT-WULF MD,TAISSIA L, PO BOX 273, 67050
19 F 91302 60 OO

GARDNER — 913 *(Johnson County Medical Society)*

NIKNIA MD,MORTEZA, PO BOX 576, 66030
884-7822
38 M 51701 78 GS

REECE MD,A THOMEN, PO BOX 576, 66030
884-8722
37 M 1902 64 FP

GARNETT — 913 *(Anderson County Medical Society)*

DOUGHERTY MD,THOMAS M, 117 W 6TH, 66032
448-5421
28 M 1902 55 FP

HARRIS JR MD,CLAIB B, 320 S OAK ST, 66032
17 M 1902 44 OO

HENDERSON MD,DAVID V, PO BOX C HWY 59 & 3RD, 66032
448-5421
48 M 1902 80 FP

LEITCH MD,DAVID A, GARNETT MED CTR 117 W 6TH, 66032
448-5421
38 M 1902 64 FP

STEVENS MD,MILDRED J, 202 W 4TH, 66032
448-5454
23 F 1902 47 FP

GIRARD — 316 *(Crawford-Cherokee County Medical Society)*

STEVENS MD,MILDRED J, 605 W ST JOHN, 66743
23 F 1902 47 FP

HALL MD,WESLEY H, PO BOX 158, 66743
724-6154
25 M 1902 57 FP

GLASCO — 913 *(Cloud County Medical Society)*

HARWOOD MD,CLAUDE J, PO BOX 428, 67445
568-2245
25 M 1902 55 FP

GODDARD — 316 *(Sedgwick County Medical Society)*

GOODWIN MD,MARY K, PO BOX 560, 67052
267-0865
53 F 1902 80 FP

PARMAN MD,CRAIG R, 216 N MAIN BOX 560, 67052
794-8655
56 M 1902 87 FP

PULLUM D.O., RICHARD W, RR 1 BOX 270, 67052
945-9161
27 M 1875 80 R

GOODLAND — 913 *(Northwest Kansas Medical Society)*

AUSTIN MD,KENNETH D, 520 MAIN, 67735
899-5651
33 M 3005 68 FP

LONG MD,LLOYD O, 520 MAIN, 67735
899-5651
37 M 1720 76 FP

MCCULLOUGH MD,ROBERT C, 520 MAIN PO BOX 180, 67735
899-5651
25 M 702 66 GP

GREAT BEND — 316 *(Barton County Medical Society)*

BEAHM MD,ANOL W, 3923 BROADWAY, 67530
793-7827
16 M 1902 43 FP

BEAHM MD,DONALD E, MED ARTS BLDG 3923 BROADWAY, 67530
792-3626
45 M 1902 72 OPH

BROZEK MD,JEFFREY E, 1309 POLK, 67530
792-5341
57 M 1902 84 FP

CAVANAUGH MD,CLAIR J, C K M C 3515 BROADWAY, 67530
792-2617
23 M 1803 52 R

EVANS MD,WILLIAM R, 1912 LINCOLN, 67530
25 M 1902 53 OO

FIESER MD,CARL W, 3515 BROADWAY, 67530
792-2617
45 M 1902 75 R

FLESKE MD,LEONARD T, 1514 K 96 HWY, 67530
792-4383
49 M 1902 75 ORS

GATENO MD,JOSEPH, 1031 JACKSON, 67530
793-8429
25 M 64901 76 OBG

HILL MD,LARY MICHAEL, 1309 POLK, 67530
793-8141
51 M 1902 78 FP

HOLT MD,JOHN M, PO BOX 1328, 67530
793-8429
35 M 1902 62 IM

JONES MD,EDWARD L, 3515 BROADWAY, 67530
792-2511
35 M 1902 62 PATH

KING MD,WILLIAM T, 3421 FOREST, 67530
793-3501
35 M 1902 62 OBG

KRUEGER MD,HAVEN C, 1023 JACKSON SQUARE, 67530
792-2163
32 M 1902 62 PD

MCALLASTER MD,WENDALE E, 2111 FOREST, 67530
793-3591
24 M 1902 54 GS

NIEDEREE MD,W CURTIS, 3520 LAKIN, 67530
793-3091
30 M 3006 57 GS

PECK MD,ROGER, PO BOX 1328, 67530
793-8429
54 M 1902 84 IM

POLSON MD,ROBERT C, BOX A 1422 POLK, 67530
793-8414
17 M 1902 42 OPH

PRESTON MD,RICHARD, PO BOX 1328, 67530
793-8429
42 M 1902 70 IM

REPLOGLE MD,CHARLES B, 2111 FOREST, 67530
793-3591
27 M 1902 53 FP

RUIZ MD,CARLOS M, PO BOX 1348, 67530
792-3210
25 M 27501 70 P

SAYLER MD,JEROME, CTRL KS MED CTR 3515 BROADWAY, 67530
792-2511
20 M 4113 64 PATH

SCHUETZ MD,PERRY N, 1422 POLK BOX A, 67530
793-8414
45 M 1902 72 OPH

SCHUKMAN MD,JAY S, 1309 POLK, 67530
792-5341
50 M 1902 76 FP

SHIVEL MD,DAVID G, 3523 FOREST, 67530
793-3523
28 M 1902 55 FP

SMITH MD,PERRY MILTON, 1309 POLK, 67530
792-5341
52 M 1902 78 FP

UNREIN MD,ROBERT J, 1017A JACKSON, 67530
792-2504
29 M 1902 59 FP

WHITE MD,CHARLES L, 2412 DOVE TERR, 67530
06 M 1902 36 OO

WIKOFF MD,DONALD L, 3520 LAKIN STE 108, 67530
792-7353
49 M 3005 82 U

YOUN MD,HWAN, 3515 BROADWAY, 67530
792-2617
48 M 58310 82 DR

ZURITA MD,MARCOS, PO BOX 1241, 67530
793-3422
46 M 31901 82 ANES

GREENSBURG — 316 (Iroquois County Medical Society)

BRADLEY MD,J RODERICK, 502 S WALNUT, 67054
723-2127
23 M 1902 47 FP

CANNATA MD,GENE, 502 S WALNUT, 67054
723-2127
54 M 1902 81 FP

WALDORF JR MD,MELVIN H, BRADLEY-WALDORF 502 S WALNUT, 67054
723-2127
23 M 1902 47 FP

HALSTEAD — 316 (Harvey County Medical Society)

AILLON MD,ALEJANDRO J, HERTZLER CL 320 WALNUT, 67056
835-2241
39 M 26402 74 TS

BEUGELSDIJK MD,HENRY PETER, 421 SPRUCE, 67056
835-2241
49 M 1902 77 ANES

BOUDREAUX MD,VELTIN J, PO BOX 53, 67056
835-2241
37 M 4812 72 R

BURNETT MD,A DEAN, 504 COLLEGE, 67056
21 M 1902 52 OO

DECKER MD,DONALD D, HERTZLER CL 320 WALNUT, 67056
835-2241
31 M 1902 56 CD

EASTES MD,GARY DEAN, HERTZLER CL 320 WALNUT, 67056
835-2241
44 M 4812 78 U

GNAU MD,FREDRIC B, 803 MAIN, 67056
835-2241
42 M 1902 69 OTO

HARMS MD,WILMER A, HERTZLER CL 320 WALNUT, 67056
835-2241
22 M 1902 56 OPH

HOOFER MD,WILFORD D, HERTZLER CL 320 WALNUT, 67056
835-2241
30 M 1902 55 TS

HURWITZ MD,MICHAEL A, HERTZLER CL 320 WALNUT, 67056
835-2241
50 M 2301 84 HEM

KIMMEL MD,KENNETH K, 4TH & CHESTNUT, 67056
835-2241
52 M 1902 78 IM

MALONE MD,EUGENE M, HERTZLER CL 320 WALNUT, 67056
835-2241
23 M 1902 56 IM

MARSH MD,CONNIE M, 1102 CHESTNUT, 67056
835-3435
47 F 1902 78 IM

MARSH MD, GENE E, HERTZLER CL 320 WALNUT, 67056
 835-2241
 47 M 1902 76 GS

SHAH MD, SHARFUDDIN, HERTZLER CL 320 WALNUT, 67056
 835-2241
 31 M 70401 71 IM

STOFFER MD, ROBERT P, HERTZLER CL 320 WALNUT, 67056
 835-2241
 26 M 1902 48 IM

TEJANO MD, NEONILLO A, HERTZLER CL 320 WALNUT, 67056
 835-2241
 43 M 74808 72 ORS

WELCH MD, JACK W, HERTZLER CL 320 WALNUT, 67056
 18 M 1902 51 OO

WILSON MD, H RANDOLPH, HERTZLER CL 320 WALNUT, 67056
 835-2241
 20 M 4112 77 GYN

HANOVER — 913 *(Northeast Kansas Medical Society)*

WARREN MD, LINDA D, BOX 38, 66945
 337-2214
 44 F 1902 71 FP

WARREN MD, ROGER D, BOX 38, 66945
 337-2214
 31 M 1902 57 GS

HAYS — 913 *(Central Kansas Medical Society)*

ALBERS MD, ROBERT C, 2501 E 13TH STE 10, 67601
 625-4224
 48 M 82 IM

APPLEGATE JR MD, FRANCIS R, 1010 DOWNING, 67601
 628-8218
 30 M 1902 55 OPH

BULA MD, RALPH E, 3209A WILLOW, 67601
 12 M 1902 37 OO

CARLSON MD, EARL V, DRAWER 430, 67601
 628-8221
 31 M 3005 65 ORS

CECIL III MD, JOHN, BOX 833, 67601
 625-6521
 43 M 4804 72 R

COOK D O, RANDY A, 105 W 13TH, 67601
 628-3608
 52 M 2878 IM

DYCK MD, ERIC LEE, 1605 OAKMONT, 67601
 628-6151
 52 M 1902 80 FP

EDDY MD, VICTOR M, 105 W 13TH, 67601
 625-2551
 29 M 1902 56 GS

HAGLER MD, JAMES P, 217 W 24TH, 67601
 13 M 3006 39 OO

HALLING MD, L WILLIAM, 1300 EAST 13TH, 67601
 625-5646
 27 M 5002 68 PATH

HUTCHISON MD, GLEN C, 3200 COUNTRY LANE, 67601
 628-8251
 21 M 1902 50 ANES

HUTCHISON MD, MARC K, 213 CASTILLIAN GARDENS, 67601
 628-6760
 00 M 82 ANES

HUTCHISON MD, MICHAEL C, #4 STONEWOOD ESTATES, 67601
 628-1160
 53 M 1902 80 ANES

KANE JR MD, WILLIAM M, 2503 CANTERBURY RD, 67601
 628-3245
 27 M 1001 62 OBG

KELLY MD, A CHRISTINE, 2501 E 13TH SUITE 7, 67601
 628-3217
 49 F 2846 81 GS

KIFER MD, C JAMES, BOX 833, 67601
 625-6521
 45 M 1902 72 DR

LASLEY MD, MICHAEL B, 2501 EAST 13 STE 7, 67601
 628-3217
 45 M 1902 76 GS

LOEB MD, ELBIE L, 2501 E 13TH STE 10, 67601
 625-4224
 51 M 1902 79 IM

MATTICK MD, IRVIN H, 2818 N VINE, 67601
 628-8221
 18 M 2802 54 ORS

MCDONALD MD, KEVIN R, PO BOX 1176, 67601
 628-6014
 52 M 3006 83 U

NEIL MD, ROY N, 105 W 13TH, 67601
 628-8341
 38 M 3005 71 PATH

NEWCUMB MD, WARD M, 1300 E 13TH, 67601
 625-5646
 37 M 3005 75 PATH

REYNOLDS MD, JEFFREY C, 2517 CANTERBURY RD, 67601
 625-7311
 39 M 1902 65 ENT

RICHARDS MD, DALLAS LEE, 2501 E 13TH STE 10, 67601
 625-4224
 49 M 1902 76 IM

SILER MD, EUGENE T, 1010 DOWNING, 67601
 628-8218
 24 M 1902 52 OPH

STADALMAN MD, ROSS EUGENE, 2501 E 13TH STE 7, 67601
 628-3217
 47 M 1902 74 GS

STUMP MD, HARL G, 105 W 13TH, 67601
 625-2551
 39 M 1902 66 GS

WATTS MD, HARRY E, 1010 DOWNING, 67601
 628-8218
 27 M 702 60 OPH

WEBER MD, WALLACE N, 2707 VINE STE 10, 67601
 628-3231
 43 M 1902 70 D

WERTH MD, DARREL D, PO BOX 1176, 67601
 628-6014
 50 M 1902 76 U

WILCOX JR MD, HOWARD L, PO DRAWER 430, 67601
 628-8221
 44 M 1902 71 ORS

HAYSVILLE — 316 *(Sedgwick County Medical Society)*

MAGSALIN MD, ROMULO D, 141 N MAIN, 67060
 529-2151
 40 M 74808 78 PATH

HERINGTON — 913 *(Dickinson County Medical Society)*

BUSTOS MD, JONAS G, 1005 NORTH B, 67449
 258-3705
 41 M 74810 76 GS

DOZIER MD, FRED S, 1005 NORTH B, 67449
 10 M 4804 47 OO

HESSTON — 316
(Harvey County Medical Society)

DIENER MD, CLAYTON H, 101 W VESPER, 67062
327-4122
18 M 1902 54 GS

YODER MD, VERNON E, ROUTE #1, 67062
283-2400
31 M 4802 68 P

HIAWATHA — 913
(Northeast Kansas Medical Society)

DUCKETT MD, THOMAS G, 201 MIAMI, 66434
10 M 1902 34 OO

HAYES MD, KRIS A, 200 DELAWARE, 66434
742-2131
54 M 1902 81 GS

LARSON MD, DELBERT L, 314 OREGON, 66434
742-2161
30 M 1803 66 FP

MEIDINGER MD, RAY, 111 S FOURTH, 66434
742-2135
03 M 3005 32 FP

SINNING MD, GARY, 314 OREGON, 66434
742-2161
49 M 1902 77 FP

HILL CITY — 913
(Central Kansas Medical Society)

REDDY MD, B N, 114 E WALNUT, 67642
674-2191
38 M 49557 80 RT

REDDY MD, P JAGANNADHA, 80 WALNUT DR, 67642
674-2255
42 M 49511 73 GS

HILLSBORO — 316
(Marion County Medical Society)

ENS MD, GERHARD GEORGE, 613 S MAIN, 67063
947-5931
20 M 1902 55 FP

ENS MD, PETER D, 209 S MAIN, 67063
947-3671
14 M 1902 51 FP

HOISINGTON — 316
(Barton County Medical Society)

FERNANDEZ MD, HECTOR O, 351 W TENTH, 67544
653-4944
41 M 74809 76 GS

FLANNER MD, FRANK R, 353 W TENTH, 67544
653-4138
43 M 1902 83 FP

MOORE MD, ROBERT, 814 NORTH ELM, 67544
653-2151
22 M 3901 53 FP

HOLTON — 913
(Shawnee County Medical Society)

HUTCHINS MD, JOEL R, 418 W 5TH PO BOX 466, 66436
364-2126
49 M 1902 84 FP

MOSER MD, ERNEST C, 438 HILLCREST DR, 66436
09 M 1902 34 OO

HORTON — 913
(Northeast Kansas Medical Society)

BRUNGARDT MD, GERARD S, 1903 EUCLID, 66439
486-2828
57 M 1902 87 IM

FRANCISCO MD, EDGARDO, PO BOX 6, 66439
486-2646
31 M 74802 74 GP

WALTON MD, PHILIP D, 1903 EUCLID, 66439
486-2828
32 M 1902 64 FP

HOXIE — 913
(Northwest Kansas Medical Society)

NEUENSCHWANDER MD, JOHN, PO BOX 258, 67740
675-3292
26 M 2802 52 FP

NEUENSCHWANDER MD, JOHN RAND, PO BOX 258, 67740
675-3292
47 M 1902 73 FP

HUGOTON — 316
(Seward County Medical Society)

FREDERICK MD, M F, 1006 S JACKSON, 67951
544-2784
20 M 1902 44 FP

WINGER MD, RAYMOND E, 1006 S JACKSON, 67951
544-2424
51 M 1902 FP

HUMBOLDT — 316
(Southeast Kansas Medical Society)

LONG MD, EDWARD E, 8TH & NEW YORK, 66748
473-2411
21 M 1902 50 FP

HUTCHINSON — 316
(Reno County Medical Society)

ADAMS JR MD, MARCUS W, 2101 N WALDRON, 67502
663-6121
33 M 3901 67 PD

ALBRIGHT MD, JEROLD D, 2101 N WALDRON, 67502
663-6121
39 M 1902 67 FP

BARKER MD, STANTON L, 2101 N WALDRON, 67502
663-6121
54 M 1902 82 FP

BAUER MD, THOMAS A, 2101 N WALDRON, 67502
663-6121
41 M 1902 68 IM

BLANK MD,JOHN N, ROUTE 5 BOX 220, 67502

07 M 1902 38 OO

BORRA MD,MARIO J, 1 WEST 8TH, 67501

662-1751
24 M 2401 54 U

BOS MD,NORMAN C, 2101 N WALDRON, 67502

663-6121
24 M 1611 61 ORS

BOUDA MD,DAVID W, 2101 WALDRON, 67502

663-6121
45 M 1902 81 IM

BRADA MD,DONALD ROBERT, 308 W 20TH, 67501

662-6041
39 M 1902 65 P

BYERS MD,MARTHA S, 1100 N MAIN, 67501

663-2151
54 F 1902 81 FP

CASEY MD,JAMES, 1100 N MAIN, 67501

663-6121
42 M 3005 77 PD

CHERVEN MD,PHILIP L, 1100 N MAIN, 67501

662-3364
45 M 2501 77 PD

COKER JR MD,GRADY N, 1100 N MAIN, 67501

663-2151
25 M 1201 OBG

DEPENBUSCH MD,FRANCIS L, 1708 E 23RD, 67502

663-7187
38 M 1902 66 OPH

ECKART MD,DE MERLE E, 2517 E 45TH, 67501

14 M 1902 40 OO

FALTER MD,RICHARD T, 1708 E 23RD ST, 67501

663-7187
38 M 1902 68 OPH

GRAVES MD,KATHRYN, 2101 N WALDRON, 67502

663-6121
49 F 1902 76 D

HALE MD,RALPH, 37 LINKSLAND DR, 67501

18 M 1902 46 OO

HEDRICK MD,KENNETH E, 2101 N WALDRON, 67502

663-6121
27 M 1902 53 GS

HOLDERMAN MD,WALLACE D, 2101 N WALDRON, 67502

663-4406
28 M 1902 54 ORS

ISSINGHOFF MD,CHAD J, 2101 N WALDRON, 67502

663-6121
55 M 1902 86 PD

JARROTT MD,JOHN B, 1100 N MAIN, 67501

663-2151
16 M 1902 40 ORS

JOHNSON MD,RICHARD L, 2101 N WALDRON, 67502

663-6121
00 M 82 R

KLOSTERHOFF MD,BRUCE E, 720 N MAIN STE 302, 67501

662-6041
45 M 1611 72 P

LESSER MD,DANE A, 2101 N WALDRON, 67502

663-6121
49 M 3901 81 U

LETTNER MD,HANS T, BOX 159, 67501

662-7801
23 M 40716 64 PATH

LUKENS MD,DAVID, 2101 N WALDRON, 67502

663-1136
24 M 2307 50 IM

MCCOY MD,CHARLES T, 310 WOLCOTT BLDG, 67501

16 M 1902 41 OO

MCMULLEN MD,JOSEPH E, 2101 N WALDRON, 67502

663-6121
33 M 1902 63 GS

MILLS MD,STEPHEN C, 1100 N MAIN, 67501

663-2151
00 M DR

NANNEY MD,GREGORY D, 2101 N WALDRON, 67502

663-6121
55 M 3901 86 HEM

NEEL MD,WILBUR B, 2101 N WALDRON, 67502

663-6121
24 M 1902 60 IM

NUNEMAKER MD,MARION E, PO BOX 1129, 67501

21 M 1902 46 OO

OPENSHAW MD,CALVIN R, 2020 N WALDRON, 67502

662-0569
21 M 4901 53 GS

OYER MD, FREDERICK R, 2101 N WALDRON, 67502

663-6121
43 M 1606 DR

PEASE MD,GARY L, 1712 E 23RD, 67501

662-4458
41 M 3005 77 OTO

PERKINS MD,JACK L, 2101 N WALDRON, 67502

663-6121
24 M 1902 53 FP

RATE MD,PEGGY S, 2101 WALDRON, 67501

663-6121
46 F 1902 74 PD

SAYLOR MD,RANDEL L, 2101 N WALDRON, 67502

663-6121
53 M 1720 85 OPH

SHEARS MD,ROBERT N, 1100 N MAIN, 67501

662-3364
20 M 1902 44 PD

SHERVIN MD,ADEL, 1600 N LORRAINE #120, 67501

662-1742
47 M 51703 OBG

SMITH MD,THOMAS WILLIAM, 1712 E 23RD, 67501

662-4458
43 M 1643 80 OTO

SPITZER MD,JEROME S, 1100 N MAIN, 67501

663-2151
33 M 3005 62 FP

STAFFORD MD,ROBERT W, 2101 N WALDRON, 67502

663-6121
43 M 2101 74 IM

STOUT MD,JAMES M, 2101 N WALDRON, 67502

663-6121
29 M 1902 55 FP

SUMNER MD,JOYCE R, 3011-B NUTMEG LN, 67501

26 F 1902 51 OO

SUMNER MD,MARION M, 3011 B NUTMEG, 67502

26 M 1902 52 IM

TAYLOR MD,ELWYN J, 1100 N MAIN, 67501

663-2151
34 M 1902 62 FP

TWEITO MD,DAVID H, 1100 N MAIN, 67501

662-3364
38 M 1803 69 PD

VIERTHALER MD,LYLE D, PO BOX 731, 67504

665-7211
54 M 1902 ANES

VON RUDEN MD,WILLIAM J, 10011 GOLDEN ARROW DR, 67502

663-4922
26 M 1611 67 GS

WEIDENSAUL MD,D N, 2101 N WALDRON, 67502

663-6121
50 M 1902 76 IM

WORTMAN MD,JACK A, 2101 N WALDRON, 67502

663-6121
34 M 1902 63 IM

INDEPENDENCE — 316
(Southeast Kansas Medical Society)

ATWOOD MD,LARRY C, 800 W MYRTLE, 67301
331-8610
54 M 1902 80 FP

BAIR MD,ALBERT E, PO BOX 925, 67301
16 M 1902 44 OO

BARBERA MD,PORTER E, PO BOX 1157, 67301
19 M 4707 47 OO

EMPSON MD,CHARLES L, PO BOX 848, 67301
331-6019
37 M 1902 68 FP

KNUTH MD,KENNETH L, 2900 TERRA VISTA, 67301
331-2200
22 M 1902 50 R

MYERS JR MD,EARL B, BOX 548, 67301
331-3420
32 M 2803 69 GS

STACEY MD,KIMBALL, 209 N SIXTH, 67301
331-6350
00 M 82 IM

IOLA — 316
(Allen County Medical Society)

COPENING MD,TELL B, BOX 386, 66749
365-2134
43 M 1902 70 FP

DETAR MD,GEORGE F, 826 E MADISON, 66749
365-5174
28 M 1902 57 GS

DICK MD,WILLIS G, 4 EAGLE DR, 66749
13 M 512 71 OO

LENSKI JR MD,FRANCIS X, 206 S JEFFERSON, 66749
365-3901
26 M 1606 50 FP

MYERS MD,W EUGENE, 401 E JACKSON, 66749
12 M 1902 46 OO

SCHMAUS MD,LYLE F, 1020 N JEFFERSON, 66749
99 M 1803 30 OO

JETMORE — 316
(Ford County Medical Society)

SPENCE MD,MICHAEL D, 810 W BRAMLEY PO BOX 458, 67854
357-8385
50 M 1902 77 FP

JEWELL — 913
(Mitchell County Medical Society)

PLOWMAN MD,CARL W, , 66949
99 M 1606 29 OO

JUNCTION CITY — 913
(Geary County Medical Society)

BOLLMAN MD,CHARLES S, PO BOX 397, 66441
762-4575
41 M 3901 74 GS

BRETHOUR MD,LESLIE J, 1106 ST MARYS RD, 66441
238-4151
13 M 3006 41 FP

BUNKER JR MD,HERBERT L, 1106 ST MARYS RD, 66441
238-5131
20 M 1606 47 FP

CRAIG MD,THOMAS A, 1106 ST MARYS RD STE 102, 66441
762-4255
53 M 1902 81 IM

LABHSETWAR MD,S A, MED ARTS BLDG PO BOX 1005, 66441
762-4147
39 F 49528 74 OBG

MACE MD,RONALD D, 1106 S ST MARYS RD STE 305, 66441
762-4884
42 M 3901 75 FP

O'DONNELL MD,HARRY E, 703 WEST CHESTNUT, 66441
14 M 4113 42 OO

SCOTT MD,ALEX, 507 WEST 6TH, 66441
238-2518
23 M 5605 50 FP

WRIGHT MD,STANLEY E, 700 ROCKLEDGE DR, 66441
762-4884
47 M 3901 75 OO

KANSAS CITY — 913
(Wyandotte County Medical Society)

ADAMS MD,JOYCE A, KU MED CTR 39TH & RAINBOW, 66103
588-6325
00 F PD

ALEXANDER JR MD,L GEORGE, UKMC 39TH & RAINBOW, 66103
588-2840
48 M 3607 86 CDTs

ALGIE MD,WILLIAM H, 3100 MINNESOTA #101, 66102
02 M 1902 27 OO

ALLEGRE MD,ANN, 1969 N 33RD, 66104
321-0341
50 F 1902 78 IM

ALLEN SR MD,WILLIAM R, 9201 PARALLEL, 66112
334-4110
22 M 1902 R

ALLEN,JR MD,WILLIAM R, 9201 PARALLEL, 66112
334-4110
46 M 1902 80 R

ARAKAWA MD,KASUMI, KU MED CENTER, 66103
588-6670
26 M 57211 64 ANES

ARMSTRONG MD,JEFFREY A, KU MED CENTER, 66103
588-6670
54 M 1902 80 ANES

ASHER MD,MARC A, K U MED CENTER, 66103
588-6130
36 M 1902 63 ORS

BASS JR MD,LEWIS N, 1975 N 5TH, 66101
321-2320
21 M 1902 45 PD

BATNITZKY MD,SOLOMON, K U MED CENTER, 66103
588-6835
40 M 83601 77 DR

BECKER MD,LESLIE E, 600 NEBRASKA STE 104, 66101
342-4010
23 M 1003 65 U

BENSON MD,KIRK T, KU MED CENTER, 66103 588-6670 54 M 1902 80 ANES	CROCKETT MD,CHARLES A, 155 S 18TH, 66102 342-2200 19 M 401 49 OPH
BERGIN MD,JAMES J, BETHANY MED CTR 51 N 12TH, 66102 281-8767 28 M 2407 76 IM	CULP MD,LOUIS M, 8919 PARALLEL PKWY STE 208, 66112 334-6801 24 M 1902 53 FP
BICHLMEIER MD,FRANKLIN G, 155 S 18TH, 66102 371-6800 33 M 1902 59 CDS	DANIELS MD,HERBERT A, KUMC 39TH & RAINBOW, 66103 588-6700 46 M 4002 86 ENT
BOLINGER MD,ROBERT E, KU MEDICAL CENTER, 66103 588-6022 19 M 1902 43 END	DARR MD,RICHARD B, 320 TERRACE TR WEST, 66106 676-2097 42 M 3401 72 IM
BOSILEVAC MD,FRED N, 155 S 18TH, 66102 16 M 1902 44 OPH	DAVIS MD,CHRISTOPHER G, 8010 PARALLEL PKWY, 66112 299-6075 09 M 1902 40 FP
BRACKETT JR MD,CHARLES E, KU MED CENTER, 66103 588-6117 20 M 3501 52 NS	DEMOTT MD,WAYNE R, PROVIDENCE-ST MGT HLTH CT, 66112 334-2500 34 M 4002 68 PATH
BRILLHART MD,MAXINE T, 4540 COUNTY LINE RD, 66106 262-9005 15 F 1902 50 FP	DIALLO MD,GASTON I, 600 NEBRASKA, 66117 281-2888 35 M 86905 75 GE
BROOKS MD,CHARLES L, 8919 PARALLEL, 66112 297-2400 54 M 1902 85 GE	DUJOVNE MD,CARLOS A, K U MED CENTER, 66103 588-6061 37 M 13201 73 CP
CALDERON MD,JAIME, 4631 ORVILLE STE 201, 66102 287-5556 39 M 26401 75 CD	DULIN MD,JOSE I, 6013 LEAVENWORTH RD, 66104 299-0089 51 M 84711 81 IM
CALKINS MD,JOHN W, KU MED CENTER, 66103 588-6236 51 M 1902 76 OBG	DUNCAN MD,KIRK A, 4601 ORVILLE STE 5, 66102 474-9353 53 M 1902 83 NEP
CAMERON MD,WILLIAM J, KU MEDICAL CENTER, 66103 588-6200 29 M 2501 62 OBG	DUNN MD,MARVIN I, KU MED CENTER, 66103 588-6015 27 M 1902 54 CD
CARPENTER MD,PAUL R, 155 S 18TH STE 105, 66102 371-6800 24 M 1902 50 GS	EGEA MD,FERNANDO M, 8919 PARALLEL PKWY STE 301, 66112 334-3400 37 M 13206 72 N
CHALIAN MD,ALEXANDER R, 2648 MINNESOTA, 66102 03 M 3509 57 OO	EMAMI MD,ABBAS, KU MED CENTER PED DEPT, 66103 588-6340 45 M 51703 PD
CHANG MD,C H JOSEPH, KU MED CENTER, 66103 588-6807 29 M 58301 71 R	ESTES MD,NORMAN C, KU MED CENTER SURG DEPT, 66103 588-6150 40 M 1902 84 GS
CHERNOFF MD,MARY A, 8929 PARALLEL PKWY, 66112 596-4100 56 F 1902 84 ANES	EVANS MD,RICHARD G, KU MED CTR ONCOLOGY DEPT, 66103 588-3670 35 M 511 85 TR
CHIN MD,TOM D, KUMC - HUMAN ECOLOGY DEPT, 66103 588-7175 22 M 2501 73 ID	FINLEY MD,BRENT E, KU MED CENTER OB/GYN DEPT, 66103 432-9326 52 M 1902 81 MFM
CHO MD,CHENG T, K U MED CENTER, 66103 588-6336 37 M 38501 74 PD	FLOERSCH MD,HUBERT M, 8919 PARALLEL PKWY STE 304, 66112 371-2020 08 M 1902 35 OBG
CLAWSON MD,D KAY, K U MED CENTER, 66103 588-1400 27 M 2401 83 ORS	FORET MD,JOHN D, KU MED CENTER, 66103 588-6147 26 M 1602 59 U
COALE MD,LLOYD H, 5020 GREELEY, 66104 13 M 1902 43 OO	FOSTER MD,FRANCES J, 4601 ORVILLE STE 12, 66102 287-2226 41 F 4707 68 OPH
COHN MD,STEVEN G, 8929 PARALLEL PKWY, 66112 596-4100 41 M 1902 68 ANES	FOX MD,DEANNA K, K U MED CENTER, 66103 588-6670 48 F 1902 76 ANES
CONNOR MD,CAROL S, 39TH & RAINBOW, 66103 588-5000 52 M 1902 83 GS	FRANCISCO MD,W DAVID, K U MED CTR ORS DEPT, 66103 588-6000 21 M 1902 44 ORS
COONFIELD MD,JAMES W, 1428 S 32ND, 66106 384-1630 45 M 1902 79 FP	FRENKEL MD,JACOB K, KU MED CENTER, 66103 588-7075 21 M 502 86 PATH
COX III MD,IRA L, 155 S 18TH, 66102 371-4343 43 M 1902 69 DR	FRIESEN MD,STANLEY R, KU MED CENTER, 66103 588-6108 18 M 1902 43 GS
COX MD,GLENDON G, KU MED CENTER DIAG RAD DEPT, 66103 588-6883 55 M 1902 84 DR	GERBER MD,HARRY A, THE MANOR 3231 N 61ST, 66104 96 M 5606 32 FP

GERJARUSAK MD, PRAPAS, 4601 ORVILLE STE 5, 66102
596-1313
46 M 89101 75 IM

GILHOUSEN MD, FREDERIC M, 1029 N 32ND, 66102
281-5252
40 M 1902 67 ORS

GIRI MD, SHANKER P G, KU MED CENTER, 66103
588-3610
50 M 49509 79 TR

GOERTZ MD, LEO R, 155 S 18TH ST, 66102
371-4343
22 M 1902 52 R

GOLLUB MD, STEVEN B, KU MED CTR DEPT OF MED, 66103
588-6015
53 M 1205 80 IM

GOODWIN MD, DONALD W, KU MED CENTER, 66103
588-6402
31 M 1902 76 P

GOTO MD, HIROSHI, KUMC - ANES DEPT, 66103
588-6670
42 M 57241 76 ANES

GRADY MD, KENNETH L, 155 S 18TH, 66102
321-3844
36 M 1902 73 P

GRANTHAM MD, JARED J, K U MED CENTER, 66103
588-6075
36 M 1902 69 NEP

GREENBERGER MD, N J, KU MEDICAL CENTER, 66103
588-6001
33 M 3806 72 IM

GRUENDEL MD, RICHARD A, 1029 N 32ND, 66102
281-5252
29 M 1902 55 ORS

GRUENDEL MD, VIRGINIA T, 6926 GARFIELD, 66102
299-2787
30 F 1902 55 FP

GUARDIA MD, DAVID K, UKMC OBG DEPT 39TH & RAINBOW, 66103
588-6238
52 M 1902 81 OBG

GUMUCIO MD, MARIO L, 6013 LEAVENWORTH RD, 66104
299-2069
30 M 64901 67 IM

HALL III, MD, THOMAS B, KU MED CENTER, 66103
588-1330
00 M GS

HANCOCK MD, ALAN C, 9201 PARALLEL, 66112
299-1474
35 M 1902 65 FP

HARA MD, GLENN S, KU MED CENTER, 66103
588-6200
43 M 514 73 OBG

HARDIN MD, CREIGHTON A, KU MED CENTER, 66103
588-6106
18 M 5605 48 GS

HART MD, KELLY Z, 155 S 18TH, 66102
371-4343
50 M 1902 76 DR

HARTMAN MD, CHARLES R, K U MED CENTER, 66103
588-6111
37 M 1902 67 IM

HENDRICKS MD, K DWIGHT, 8919 PARALLEL PKWY STE 226, 66112
299-8800
53 M 1611 80 OPH

HENNEY MD, JANE E, KU MED CENTER, 66103
588-1440
47 F 1720 85 IM

HERMRECK MD, ARLO S, K U MED CENTER, 66103
588-7232
38 M 1902 66 GS

HIEBERT MD, JOHN M, KU MED CTR PLASTIC SURG, 66103
588-6143
42 M 2405 80 PS

HODLEY MD, WILLIAM D, KU MED CENTER-MEDICINE, 66103
588-3974
31 M 1902 56 IM

HODGES MD, GLENN R, K U MED CENTER, 66103
588-6035
41 M 1602 74 ID

HODGSON MD, JAMES F, 8919 PARALLEL, 66112
299-8000
45 M 4813 81 OBG

HOLDCRAFT MD, JACQUELYNE, 255 NEW BROTHERHOOD BLDG, 66101
321-1161
36 F 2105 68 ENT

HOLLOWELL MD, JOSEPH G, KU MEDICAL CENTER PED DEPT, 66103
588-5906
32 M 4501 70 PD

HOLMES MD, FREDERICK F, KUMC, 66103
588-6005
32 M 5404 69 IM

HOLMES MD, GRACE E, KUMC, 66103
588-6325
32 F 5404 68 PD

HOLMES MD, JOHN A, 155 S 18TH, 66102
621-1188
47 M 1902 78 IM

HUERTER MD, QUENTIN C, 8919 PARALLEL STE 226, 66112
299-8800
31 M 1902 60 OPH

HUNT EXEC SEC, MARTHA, WYANDOTTE COUNTY MED SOC, 66102
321-9460
00 F

IBARRA MD, RICHARD C, 754 PACIFIC, 66101
342-3969
26 M 64902 63 FP

ILIOPOULOS MD, JOHN I, KU MED CENTER, 66103
588-6197
44 M 41801 81 GS

INGRAM MD, JOHN E, 1428 S 32ND, 66106
384-1630
24 M 3006 57 FP

ISERN MD, HENRY J, 4601 ORVILLE STE 12, 66102
287-2226
43 M 84706 OPH

JACOBS MD, DAVID S, 8929 PARALLEL PARKWAY, 66112
596-4725
31 M 2501 65 PATH

JACOBS MD, RAE R, K U MED CENTER, 66103
588-6163
36 M 3506 72 ORS

JACOBSON MD, EUGENE D, KUMC OFFICE OF DEAN SCH OF MED, 66103
588-5287
30 M 5002 IM

JAHANIAN MD, DARYOUSH, 8919 PARALLEL PKWY STE 304, 66112
334-5420
40 M 51701 74 OBG

JAYARAM MD, MARANDAPALLI R, 8919 PARALLEL, 66112
492-6200
42 M 49509 73 PD

JEWELL MD, WILLIAM R, KU MED CENTER, 66103
588-6112
35 M 1611 72 GS

JOHNSON MD, BRUCE E, KU MED CENTER, 66103
588-6000
50 M 514 78 IM

JONES JR MD, HERMAN H, 600 NEBRASKA, 66101
342-4010
25 M 4707 56 GS

JONES MD, BARBARA, KU MEDICAL CENTER, 66103
588-6339
28 F 4901 PD

KEPES MD, JOHN J, K U MED CENTER - PATH DEP, 66103
588-7076
28 M 47301 62 PATH

KIM MD,JONG M, UKMC 39TH & RAINBOW, 66103 588-6670 40 M 58302 74 ANES	MANI MD,MANI M, KUMC 39TH & RAINBOW, 66103 588-6142 37 M 49527 74 PS
KING MD,CHARLES R, K U MEDICAL CENTER, 66103 588-6200 47 M 1902 73 OBG	MARTIN MD,JOSEPH P, 9201 PARALLEL, 66112 334-1515 49 M 1902 78 IM
KIRCHNER MD,FERNANDO R, 155 S 18TH SUITE 270, 66102 371-7333 30 M 64901 63 OTO	MARTIN MD,NORMAN L, K U MED CENTER, 66103 588-6800 36 M 1902 63 DR
KOVAC MD,ANTHONY L, KU MED CENTER ANES DEPT, 66103 588-6670 52 M 1902 81 ANES	MARTIN MD,RONALD L, KU MED CENTER PSYCHIATRY, 66103 588-6412 45 M 1606 80 P
KRANTZ MD,KERMIT E, KU MED CENTER, 66103 588-6201 23 M 1606 59 OBG	MASTERS MD,FRANCIS W, KU MED CENTER, 66103 588-6142 20 M 3545 58 PS
KRUG MD,PAUL E, K U MED CENTER, 66103 588-6670 54 M 1902 ANES	MATHEWSON MD,HUGH S, KUMC 39TH & RAINBOW, 66103 588-6675 21 M 1902 44 ANES
KWEE MD,SIOE T, 8929 PARALLEL PKWY, 66112 596-4723 36 F 1720 70 PATH	MATTIOLI MD,LEONE, KU MED CENTER, 66103 588-6311 32 M 56115 69 PDC
LAING MD,ROBERT R, 155 S 18TH, 66102 371-4301 37 M 1643 62 GE	MCCARTHY MD,ROBERT P, 8919 PARALLEL STE 231, 66112 334-9003 25 M 2834 54 U
LAWWILL MD,THEODORE, K U MED CENTER, 66103 588-6605 37 M 4705 80 OPH	MCCUNE MD,MARK A, 8919 PARALLEL PKWY, 66112 492-6200 52 M 1902 81 D
LAYBOURNE JR MD,PAUL C, KU MED CENTER, 66103 588-6475 19 M 3509 49 CHP	MCMILLAN MD,JOHN H, KU MED CENTER, 66103 588-6800 52 M 1645 80 DR
LEE MD,JAE M, 155 S 18TH #105, 66102 371-6800 40 M 58302 74 GS	MEBUST MD,WINSTON K, KU MED CENTER, 66103 588-6146 33 M 5404 66 U
LEE MD,KYO R, KUMC 39TH & RAINBOW, 66103 588-6800 33 M 58302 73 R	MEDHAT MD,MOHAMED A, KU MED CENTER REHAB MED, 66103 588-6798 32 M 33002 80 RM
LEMOINE JR MD,ALBERT N, K U MED CENTER, 66103 588-6600 18 M 2802 47 OPH	MILLER MD,DENNIS W, 600 NEBRASKA STE 102, 66101 621-4001 49 M 4707 82 OBG
LEO MD,WILLIAM A, K U MED CENTER, 66103 588-6109 22 M 1902 52 GS	MILLIGAN MD,DONALD B, KU MED CENTER, 66103 588-1937 48 M 2307 75 FP
LEVINE MD,ERROL, K U MED CENTER, 66103 588-6800 41 M 83601 77 DR	MOELLER MD,DONALD D, 155 S 18TH, 66102 371-4301 34 M 1902 61 GE
LIEBERMAN MD,BRUCE IRWIN, KU MED CENTER, 66103 588-6300 49 M 3819 79 PD	MOORE MD,WAYNE V, K U MED CENTER, 66103 588-6336 42 M 2604 74 PD
LINDSLEY MD,CAROL B, K U MED CENTER, 66103 588-5907 41 F 5404 74 PD	MORAN MD,JON FREDERICK, KU MED CTR THOR & CD SURG, 66103 588-6107 46 M 2802 85 TS
LINN MD,CATHERINE P, 8919 PARALLEL #440, 66112 788-9797 52 F 1902 80 OBG	MORFFI MD,RAUL R, 1225 N 78TH, 66112 287-8300 25 M 27501 67 IM
LIU MD,ALBERT T, 8919 PARALLEL, 66112 788-9797 49 M 1902 80 OBG	MURPHY MD,ROBERT C, KUMC 39TH & RAINBOW, 66103 588-6136 53 M 4705 86 PS
LIU MD,CHIEN, UKMC MED CTR 39TH & RAINBOW, 66103 588-6035 21 M 24217 59 ID	NEFF MD,JAMES R, KU MED CENTER, 66103 588-6198 40 M 1902 67 ORS
LUKERT MD,BARBARA P, KU MED CENTER, 66103 588-6048 34 F 1902 61 END	NEIGHBOR MD,ERNEST H, 1420 S 42ND, 66106 831-3433 40 M 1902 67 ORS
LYNCH MD,SEAN R, KU MED CENTER, 66103 588-6031 38 M 83601 77 HEM	NEIGHBOR MD,GAYLORD P, 1420 S 42ND, 66106 831-3433 13 M 1902 41 FP
MAINSTER MD,MARTIN A, KU MED CENTER, 66103 588-6600 42 M 4802 84 OPH	NIBBELINK MD,LARRY WAYNE, 8919 PARALLEL #440, 66112 371-2330 48 M 2803 79 OBG
MANGOLD MD,JOEL VOYCE, KU MED CENTER, 66103 588-6670 50 M 1902 77 ANES	NOBLE MD,MARK J, KU MED CENTER-UROLOGY, 66103 588-6148 49 M 2501 81 U

NORRIS MD, CHARLEY W, KUMC, 66103
588-6700
33 M 1902 65 OTO

O'BOYNICK II MD, PAUL LEONARD, KU MED CENTER, 66103
588-5000
48 M 1902 79 NS

O'BRYAN MD, JAMES J, KU MED CENTER PED DEPT, 66103
588-5398
47 M 1902 76 PD

O'DELL MD, MICHAEL L, KU MED CTR DEPT OF FP, 66103
588-1908
51 M 1902 83 FP

OTHMER MD, EKKEHARD, K U MEDICAL CENTER, 66103
588-6440
33 M 40721 77 P

OXLER JR MD, JOHN EDWARD, 155 S 18TH, 66103
362-6161
46 M 1902 74 IM

PALMER MD, MARVIN M, 8919 PARALLEL PKWY, 66112
788-9797
45 M 702 77 OBG

PARDO MD, LILLIAN G, KU MEDICAL CENTER, 66103
831-6373
39 F 74802 79 PDN

PARDO MD, MANUEL P, K U MEDICAL CENTER, 66103
588-6464
35 M 74801 73 P

PAREKH MD, AJITKUMAR M, 6013 LEAVENWORTH RD, 66104
299-2069
47 M 49501 77 PUD

PAREKH MD, MADHAVI A, 6013 LEAVENWORTH RD, 66104
299-2069
47 F 49501 85 FP

PARRA MD, DANIEL C, 6013 LEAVENWORTH RD, 66104
299-2069
43 M 84703 83 FM

PARRA MD, MIGUEL D, 6013 LEAVENWORTH RD, 66104
299-2088
37 M 84710 70 FP

PAZELL MD, JOHN A, 4631 ORVILLE, 66102
287-6464
40 M 2501 73 ORS

PERRY JR MD, LAWRENCE L, KUMC 39TH AT RAINBOW, 66103
588-6522
34 M 1902 73 FP

PIERCE MD, GEORGE E, KUMC - PO BOX 255, 66103
588-6115
33 M 2307 72 TS

PORTER MD, DAVID M, 4517 TROUP, 66102
287-8800
39 M 4707 69 PD

PORTER MD, SUSAN S, KU MED CTR ANES DEPT, 66103
588-6670
54 F 1902 81 ANES

POTTER MD, ROBERT L, 1969 N 33RD, 66102
321-0341
38 M 1902 64 IM

POWERS MD, G ROBERT, 8919 PARALLEL PKWY, 66112
299-8000
33 M 1902 67 FP

PRESTON MD, DAVID F, KU MED CENTER, 66103
588-6810
33 M 3841 74 NM

PRETZ MD, JAMES B, 1610 WASHINGTON BLVD, 66102
342-2442
24 M 1902 47 FP

PRICE MD, JAMES GORDON, K U MED CENTER, 66103
588-6510
26 M 702 78 FP

PRIETO MD, JORGE N, 6013 LEAVENWORTH RD, 66104
299-2069
45 M 26401 76 GS

PUGH MD, DAVID M, K U MED CENTER, 66103
588-6015
29 M 801 64 CD

QUINN MD, CHARLES E, 4601 ORVILLE, 66102
287-6604
43 M 4707 75 OBG

RECKLING MD, FREDERICK W, KU MED CENTER, 66103
588-6129
34 M 3545 66 ORS

REDDY MD, EASHWER K, K U MED CENTER - RAD DEPT, 66103
588-7350
44 M 49597 74 TR

REDFORD MD, JOHN W B, K U MED CENTER, 66103
588-6777
28 M 6501 74 PM

REEB MD, RONALD JOSEPH, 155 S 18TH, 66102
371-4343
46 M 3006 79 DR

REED MD, JAMES STEWART, K U MED CENTER, 66103
588-6019
46 M 3601 79 GE

RHODES MD, JAMES B, KU MEDICAL CENTER, 66103
588-6019
28 M 1902 66 GE

RICE JR MD, FREDERICK A, 1029 N 32ND ST, 66102
281-5252
36 M 4802 68 ORS

RICHARDSON MD, JAY L, 8919 PARALLEL, 66112
299-8000
38 M 1902 66 GS

RILEY MD, RAY B, 2020 ORVILLE, 66102
06 M 1902 36 OO

RISING MD, JESSE D, KU MEDICAL CENTER, 66103
588-1934
14 M 1902 38 IM

ROBINSON MD, RALPH G, KU MEDICAL CENTER, 66103
588-6810
37 M 1902 63 NM

ROOK MD, LEE E, 1111 S 55TH, 66106
831-2834
09 M 1902 38 FP

ROSENBERG MD, ALLAN J, KU MED CENTER PED DEPT, 66103
588-6339
38 M 2407 PD

ROSENTHAL MD, STANTON J, K U MED CENTER, 66103
588-6800
46 M 1902 72 DR

ROTH MD, ALAN E, BETHANY HOSP 51 N 12, 66102
281-8814
35 M 1902 63 PATH

SANTOS MD, FERMIN M, 6013 LEAVENWORTH RD, 66104
299-0538
49 M 84706 82 P

SCHWEGLER MD, RAYMOND A, 8919 PARALLEL PKWY, 66112
492-6200
37 M 1902 64 CD

SCHWORM MD, CURTIS P, 155 SOUTH 18TH, 66102
371-4343
47 M 3005 77 DR

SHERMAN MD, ROBERT P, 9201 PARALLEL, 66112
334-0040
34 M 1902 64 PUD

SNYDER MD, THOMAS E, UKMC 39TH & RAINBOW, 66103
588-6243
47 M 1902 82 OBG

SOUCEK MD, CHARLES D, 155 S 18TH, 66102
371-4343
31 M 3005 64 R

SPEER MD, LELAND, 910 N WASHINGTON, 66102
12 M 1902 36 OO

STEELE MD,CLARENCE H, 745 STATE STE 255, 66101
321-1161
14 M 1902 40 OTO

STEINZEIG MD,SHERMAN M, 155 S 18TH, 66102
621-1151
25 M 1902 52 CD

STUBBLEFIELD MD,CHARLES T, 8919 PARALLEL STE 440, 66112
371-2330
32 M 1902 59 OBG

TAYLOR MD,WILLIAM F, 8919 PARALLEL PKWY, 66112
299-8000
53 M 2846 82 IM

TEMPLETON MD,ARCH W, K U MEDICAL CENTER, 66103
588-6805
32 M 3005 69 R

THEROU MD,LEONA F, K U MED CENTER PED DEPT, 66103
588-5908
41 F 6701 71 PD

THOMAS MD,JAMES H, K U MED CENTER, 66103
588-5901
41 M 2012 75 GS

THOMPSON MD,DANNIE M, TWO GATEWAY CTR STE 917, 66101
321-3355
35 M 4707 68 OBG

TIOJANCO MD,REYNALDO R, 6013 LEAVENWORTH RD, 66104
799-2069
44 M 65 FP

TRUEWORTHY MD,ROBERT C, KU MED CENTER, 66103
588-6340
40 M 2802 73 PD

UNRUH MD,GREGORY K, KUMC ANES DEPT, 66103
588-6670
55 M 1902 82 ANES

VACEK MD,JAMES L, UKMC 39TH & RAINBOW, 66103
588-6015
51 M 3006 86 CD

VARGHESE MD,GEORGE, K U MEDICAL CENTER, 66103
488-6798
44 M 49509 77 PM

VATS MD,TRIBHAWAN S, K U MED CENTER PED DEPT, 66103
588-6340
40 M 49529 75 PD

WALKER MD,MAURICE A, 1417 S 37TH, 66106
831-1422
04 M 1601 28 OO

WALSH MD,DAVID J, KU MED CENTER PED DEPT, 66103
588-6371
46 M 4501 82 PDN

WALTERS MD,WILLIAM DAVID, 1428 S 32ND, 66106
384-1630
50 M 1902 81 FP

WEIGEL MD,JOHN W, UROLOGY DEPT KU MED CTR, 66103
588-6148
29 M 1902 54 U

WHITACRE MD,MARC M, KUMC OPH DEPT, 66103
588-6643
53 M 4101 84 OPH

WILLIAMS MD,FENTON A, 701 WASHINGTON, 66101
281-0361
40 M 1003 83 R

WILSON MD,DAVID B, KU MED CENTER CARDIOV DIS DPT, 66103
588-6015
54 M 4706 81 IM

WOLF MD,KARL T, 621 NORTHRUP, 66101
14 M 1902 48 OO

ZAREMSKI MD,SHERMAN C, 1200 N 38TH STE 209, 66102
596-1185
33 M 1720 64 IM

ZIEGLER MD,DEWEY K, KU MED CENTER, 66103
588-6985
20 M 2401 56 N

ZINN MD,THOMAS W, 155 S 18TH, 66102
371-4343
41 M 1902 68 R

KANSAS CITY MO — 816

AHMED MD,IFTEKHAR, 2900 BALTIMORE #390, 64108
756-2651
45 M N

ALLEN MD,MARK L, 8301 STATE LINE STE 208, 64114
361-7555
53 M 1902 83 ANES

ALLIN MD,DENNIS M, 3101 BROADWAY #1000, 64111
561-1025
57 M 1902 EM

BARELLI MD,PAT A, 2929 BALTIMORE, 64108
19 M 1902 44 ENT

BLIM MD,R DON, 4400 BROADWAY, 64111
561-8100
27 M 1902 PD

BRIDGENS MD,JAMES G, 1025 HUNTINGTON RD, 64113
363-1123
22 M 1902 47 PATH

CHAPMAN MD,JAMES H, 4801 LINWOOD BLVD, 64128
27 M 4706 69 R

CHRISTENSEN MD,SHANE R, A4812 HEINTZ, 64133
281-8881
55 M 1902 83 EM

DAVIS MD,RICHARD E, 1010 W 56TH, 64113
26 M 1902 54 OO

DEVINS MD,GEORGE S, 6700 TROOST #520, 64131
36 M 1902 62 IM

DIEHL MD,ANTONI M, 4320 WORNALL RD, 64111
753-4414
24 M 2604 53 PDC

GODFREY MD,WILLIAM A, 4320 WORNALL RD, 64111
38 M 1902 66 OPH

GRAHAM MD,WALLACE H, 6724 TROOST STE 304, 64131
363-6707
10 M 3006 GS

GUASTELLO MD,MARIO J, 4320 WORNALL, 64111
753-5663
38 M 1902 OTO

HARD MD,BENJAMIN F, 8400 HAWTHORN RD, 64120
242-2525
28 M 4802 64 OM

HEIM MD,MARY LEE, 9705 NW 77TH TERR, 64152
596-4184
42 F 2846 85 EM

HOPKINS MD,JAMES P, 6650 TROOST, 64131
523-7811
22 M 2407 85

HUNKELER MD,JOHN D, 2900 BALTIMORE STE 650, 64108
41 M 1902 85 OPH

KINDRED MD,LYNN H, 4320 WORNALL RD STE 40-II, 64111
531-5510
37 M 1902 CD

KINPORTS SR MD,EDWARD B, PO BOX 1823, 64141
15 M 1602 77 OO

LUETJE MD,CHARLES MARION, 3100 BROADWAY STE 509, 64111
531-7373
41 M 2803 78 OTO

ORR MD, STEVEN M, 4544 N OLIVE, 64116
 281-8881
 55 M 1902 81 EM

PAYNE MD, J RALPH, 3101 BROADWAY #1000, 64111
 334-2500
 40 M 1902 67 EM

POONAWALA MD, HUSENI, 11201 COLORADO, 64137
 763-5200
 33 M 49528 71 P

RYSER MD, CAROL A, 7447 HOLMES, 64131
 363-3313
 37 F 1902 63

SHECHTER MD, NATHAN, 6724 TROOST, 64131
 333-1700
 18 M 1611

SHECHTER MD, NATHAN, 4320 WORNALL SUITE 530, 64111
 753-4312
 18 M 1611

THEDINGER MD, BRADLEY S, 3100 BROADWAY STE 509, 64111
 588-6700
 53 M 1902 83 NOTO

UTLEY MD, JAMES HARMON, 4951 WESTWOOD TERR, 64112
 281-8880
 51 M 1606 77 EM

YOST JR MD, JOHN G, 6420 PROSPECT, 64132
 444-9000
 53 M 3005 ORS

ZARR MD, JAMES S, 6650 TROOST STE 306, 64131
 276-7035
 55 M 2803 86 PM

KINGMAN — 316
(Ninnescah Medical Society)

BLOOM MD, L THEIL, BOX 496, 67068
 532-5233
 32 M 1902 57 R

BOYER MD, ROBERT E, 760 AVENUE D WEST, 67068
 532-5145
 36 M 1902 63 FP

BURKET JR MD, GEORGE E, SPRING LAKE RT 1, 67068
 12 M 1902 37 OO

KINSLEY — 316
(Iroquois County Medical Society)

ATWOOD MD, M DALE, 616 NILES, 67547
 659-2114
 19 M 1902 51 FP

SCHNOEBELEN MD, RENE E, 807 EAST 4TH, 67547
 659-2141
 16 M 3901 46 FP

KIOWA — 316
(Ninnescah Medical Society)

CHRISTENSEN MD, MARION D, 220 S 8TH, 67070
 825-4121
 25 M 3901 53 FP

LA CROSSE — 913
(Central Kansas Medical Society)

BHARGAVA MD, ASHOK KUMAR, PO BOX 490, 67548
 222-2564
 37 M 49547 78 FP

BHARGAVA MD, SHOBHANA, PO BOX 490, 67548
 222-2564
 38 F 49547 81 FP

LARNED — 316
(Pawnee County Medical Society)

CRAM JR MD, OLE R, 521 CARROLL, 67550
 18 M 1902 43 OO

DAVIS MD, DAVID H, 815 W 6TH, 67550
 04 M 1902 30 OO

EWING MD, THOMAS D, 804 CARROLL, 67550
 285-3133
 22 M 1902 46 FP

SHAH MD, MIAN, SHAH CLINIC PO BOX 30, 67550
 285-3173
 32 M 70403 76 GS

SHAH MD, NASREEN, SHAH CLINIC PO BOX 30, 67550
 285-3173
 39 F 70409 76 OBG

SHEPARD MD, LEROY W, 603 W 5TH, 67550
 04 M 3006 30 OO

SMITH MD, JOHN D, 904 W 4TH, 67550
 22 M 3901 52 OO

LAWRENCE — 913
(Douglas County Medical Society)

BAILEY MD, WILLIAM A, PO BOX 127, 66044
 843-9125
 40 M 1902 67 ORS

BELOT JR MD, MONTI L, LAWRENCE NATIONAL BK BLDG, 66044
 843-3640
 13 M 1902 40 FP

BISHOP MD, RODNEY LEE, 3310 CLINTON PKY CT, 66044
 842-7200
 49 M 1902 75 IM

BOYDEN MD, MARY S, 621 CALIFORNIA, 66044
 842-3778
 14 F 2604 42 PDA

BRANSON MD, VERNON L, 346 MAINE, 66044
 842-4477
 17 M 1902 42 PD

BRUNFELDT MD, JOAN KRAUS, 404 MAINE, 66044
 842-3635
 52 F 1902 78 IM

BUCK JR MD, HENRY W, WATKINS MEM HSOP, 66045
 864-9500
 34 M 1902 61 OBG

CULVER MD, WARREN T, 3506 W TENTH, 66044
 20 M 3508 67 OO

DUNLAP MD, RICHARD L, 711 SUNSET DR, 66044
 842-4344
 12 M 3005 38 EENT

FRIESEN MD, DALE, PO BOX 521, 66044
 842-7026
 47 M 1902 75 ANES

FUNK MD, EDWARD D, 2725 MAYERICK LN, 66046
 04 M 1902 41 OO

GILLES MD, HELEN M, 1301 IOWA, 66044
 22 F 1902 45 OO

GODWIN MD, PHILLIP A, 500 ROCKLEDGE, 66044
841-6540
28 M 1902 55 ANES

GRAY MD, SCOTT E, 346 MAINE, 66044
843-0677
50 M 1902 83 OBG

HAGGAN MD, MARGARET E, 1746 N H, 66044
00 F 2501 69 OO

HASSELLE III MD, JAMES E, 346 MAINE, 66044
841-7430
35 M 4706 69 P

HATTON MD, DONALD W, 404 MAINE STE 3, 66044
842-3635
42 M 1902 69 IM

HIEBERT MD, DAVID L, 1112 W SIXTH, 66044
841-3211
36 M 1902 62 R

HOFFMAN MD, J PHILIP, 404 MAINE, 66044
842-3635
00 M IM

INGHAM JR MD, H LAIRD, 404 MAINE STE 3, 66044
842-3635
45 M 3901 73 IM

JETER MD, JOHN, 4224 WIMBLEDON DR, 66044
842-9176
55 M 1902 82 IM

JONES MD, H PENFIELD, MED ARTS CTR 346 MAINE, 66044
06 M 2401 33 GS

JOSEPH MD, HOWARD F, 308 MAINE, 66044
843-3981
26 M 1902 51 U

KENNEDY MD, L ELAINE, 404 MAINE, 66044
842-3635
00 M IM

LEARNED MD, GEORGE R, 401 ARKANSAS, 66044
843-5502
22 M 1902 56 GS

LOVELAND MD, G CHARLES, 346 MAINE, 66044
842-4477
47 M 1902 74 PD

MADSEN MD, GLENN L, 1112 W SIXTH, 66044
841-3211
38 M 3005 68 R

MANAHAN MD, G EUGENE, MED ARTS CTR 4TH & MAINE, 66044
842-0211
19 M 1902 44 GS

MITCHELL MD, ALEX C, 1626 W 20TH, 66044
843-4739
18 M 1902 50 PH

MODDRELL MD, CAROL A, 404 MAINE, 66044
749-6100
45 F 1902 72 PATH

NELSON MD, RICHARD O, 2425 ORCHARD LANE, 66044
11 M 1001 41 OO

O'NEAL MD, LYNN W, 1112 W 6TH #202, 66044
841-2280
00 M OPH

OELSCHLAGER MD, RONALD D, 1112 W SIXTH, 66044
841-3211
43 M 1902 70 R

ORCHARD MD, RICHARD A, 1112 W 6TH STE 202, 66044
841-2280
41 M 2802 74 OPH

OSBERN MD, LIDA, 404 MAINE, 66044
842-3635
52 F 1902 77 IM

PRAEGER MD, MARK A, 1112 W 6TH STE 204, 66044
843-2010
42 M 1902 69 GS

REED MD, JAMES S, WATKINS MEMORIAL HOSP, 66045
843-4455
23 M 1902 47 FP

REED MD, RALPH R, 404 MAINE, 66044
842-3635
27 M 1902 53 IM

REESE MD, JOHN L, 346 MAINE, 66044
842-6644
35 M 1902 62 GS

ROBERTS MD, RICHARD S, 342 WOODLAWN DR, 66044
19 M 2802 46 OO

SANDERS MD, J ALAN, LAWRENCE MEM HOSP 404 MAINE, 66044
842-2083
29 M 1902 62 PATH

SCHROEDER MD, SYDNEY O, 902 W 25TH, 66044
841-4311
18 M 1902 44 OO

SCHWEGLER MD, RAYMOND A, 1504 UNIVERSITY DR, 66044
07 M 2604 35 OO

SEGEBRECHT MD, STEPHEN L, 3012 OXFORD RD, 66044
841-5217
55 M 1902 OTO

VERNON MD, MARY C, 500 ROCKLEDGE, 66044
841-6540
52 F 1902 78 FP

WERTZBERGER MD, JOHN, PO BOX 127, 66044
843-9125
36 M 1902 64 ORS

WILCOX SR MD, HOWARD L, MED ARTS CTR 346 MAINE, 66044
843-0677
18 M 3520 56 OO

WOLLMANN MD, MARTIN, 2615 ORCHARD LN, 66044
843-4455
26 M 1902 70 IM

YOCKEY MD, CHARLES C, WATKINS MEM HOSP STU HLTH CTR, 66045
46 M 1902 77 IM

LEAVENWORTH — 913 (Leavenworth County Medical Society)

ASHKAR MD, ADNAN, 520 6TH AVE STE C1, 66048
682-6818
42 M 52801 80 OBG

BARRY MD, DAVID R, 500 EISENHOWER RD, 66048
727-6000
42 M 1902 71 FP

BUESING MD, OLIVER R, 230 NINTH, 66048
10 M 2501 76 GS

CENAC MD, MARK T, 500 EISENHOWER RD, 66048
727-6000
27 M 401 70 GS

COMBS MD, PETER S, 419 ARCH ST, 66048
682-0242
14 M 4101 46 IM

DE SOUZA MD, DERRICK J, 2201 S FOURTH, 66048
651-6030
43 M 49501 76 GS

GRAHAM MD, KENNETH L, RTE 2 BOX 182AA, 66048
727-6000
21 M 3840 48 GS

GRAHAM MD, THOMAS W, 500 EISENHOWER RD, 66048
727-6000
26 M 3840 52 IM

GRISOLIA MD, ANDRES, 210 ELM, 66048
682-2000
27 M 84708 63 ORS

HAMMEKE MD,JOHN C, 3601 S 4TH ST TRAFFICWAY, 66048
682-5201
27 M 401 66 OPH

JOHNSON MD,PAUL D, 520 SIXTH, 66048
682-2240
36 M 1902 64 FP

LIPOFF MD,JAY I, 410 S FOURTH, 66048
682-6950
50 M 3519 82 IM

MCCOLLUM MD,WILLIAM B, 3601 S FOURTH, 66048
682-1466
41 M 1902 68 TS

MERRITT MD,W HENRY, 44 WESTWOOD DR, 66048
682-6661
14 M 702 58 OO

MILLS MD,VERNON A, 500 EISENHOWER RD, 66048
727-6000
51 M 1902 80 PD

PARKER MD,ROBERT W, 500 EISENHOWER RD, 66048
727-6000
45 M 1902 71 FP

RABE MD,MELVIN A, 600 S BROADWAY, 66048
14 M 1902 37 OO

RAO MD,KAKARALA J, WARD 2 EAST VAMC, 66048
682-2000
33 M 49527 IM

SNOW MD,DONALD L, 1127 VILAS, 66048
682-1000
21 M 64901 62 OO

STEVENS MD,LEAH J, 3601 S 4TH ST TRAFFICWAY, 66048
682-2424
55 F 1902 FP

STRUTZ MD,WILLIAM C, 68 WESTWOOD DR, 66048
682-8868
08 M 5606 59 R

VOORHEES MD,CARROLL D, 520 SIXTH AVE, 66048
682-6661
25 M 1902 52 FP

VOORHEES MD,GORDON S, 520 SIXTH AVE, 66048
642-6661
12 M 1902 39 IM

LEBO — 316
(Flint Hills County Medical Society)

HUNTER MD,KENNETH R, , 66856
256-2565
07 M 1902 39 FP

HUTCHISON MD,JOE R, BOX 303, 66856
256-6346
55 M 1902 86 FP

LENORA — 913
(Northwest Kansas Medical Society)

STEICHEN MD,EDWARD F, BOX 97, 67645
05 M 1601 31 FP

LIBERAL — 316
(Seward County Medical Society)

ALLEN MD,RAY E, 2 PLAZA DR, 67901
624-5691
37 M 1902 64 IM

BLOCH MD,RALPH N, 1023 N KANSAS #3, 67901
626-5800
29 M 3509 86 ORS

BRADLEY MD,FENWICK P, SOUTHWEST MED CTR PO BOX 1340, 67901
624-1651
29 M 1002 PATH

CAEDO MD,CARMELITA D, 2401 LILAC DR, 67901
624-1651
41 F 74801 77 R

ESTRADA MD,EDMUNDO C, BOX 1855, 67901
624-2565
43 M 74801 80 GS

ESTRADA MD,LINA, 1023 N KANSAS STE 3, 67901
733-1331
43 F 74801 80 PD

GRIMES MD,I ROSS, PO BOX 319, 67901
624-1676
27 M 3901 61 TS

HENDERSON II D O,ROBERT C, PO BOX 1069, 67901
624-3811
46 M 4878 86 OBG

HOLCOMB MD,WILLIAM M, 15 E 11TH, 67901
624-2252
31 M 3901 63 GS

KNUDSEN MD, DENNIS, BOX 1069, 67901
624-3811
00 M OBG

KOONS MD,JESS W, 1210 N WASHINGTON, 67901
624-3841
27 M 1902 57 OPH

NEVINS MD,RICHARD L, PO BOX 1824, 67901
624-0255
47 M 3901 75 FP

PROCHAZKA MD,OTTO F, 1105 ELM, 67901
12 M 1902 38 OO

RATHBUN MD,EDWIN D, 610 W 11TH, 67901
624-1841
36 M 1902 63 FP

REESE MD,JACK D, 15 E 11TH, 67901
624-6226
32 M 1902 57 FP

WADE MD,THEODORE E, 318 N LINCOLN, 67901
354-5275
04 M 512 57 OO

ZAINALI MD,ASSADOLLAH, 601 LILAC DR, 67901
624-1651
46 M 51701 79 R

LINDSBORG — 913
(McPherson County Medical Society)

FREDRICKSON MD,DUANE E, 121 W LINCOLN, 67456
227-3371
39 M 1902 67 FP

MURFITT MD,MALCOLM C, 231 N MAIN, 67456
13 M 801 46 OO

LYNDON — 913
(Franklin County Medical Society)

STOUT MD,NILES M, , 66451
828-4521
16 M 1902 50 FP

LYONS — 316
(Rice County Medical Society)

GRIMES MD,JAMES T, 1221 W NOBLE, 67554
257-5124
27 M 1902 53 FP

SIEMENS MD,RICHARD A, 1221 W NOBLE, 67554
 257-5124
 30 M 1902 60 FP

TOBIAS MD,ROGER R, 1017 S BELL, 67554
 257-5182
 51 M 1902 82 FP

MANHATTAN — 913

(Riley County Medical Society)

BAKER MD,RICHARD B, 2600 ANDERSON, 66502
 537-4200
 42 M 4113 76 ORS

BALL MD,RALPH G, 215 S DELAWARE, 66502
 03 M 1902 27 OO

BARLOW MD,JOHN M, 1133 COLLEGE, 66502
 539-3504
 45 M 1102 81 OTO

BASCOM MD,GEORGE S, 1133 COLLEGE, 66502
 539-5341
 27 M 2401 59 GS

BOESE MD,KENNETH M, 1133 COLLEGE, 66502
 776-4744
 25 M 1902 56 FP

CATHEY MD,ROBERT H, 1133 COLLEGE, 66502
 537-4990
 42 M 1902 68 D

CRANE MD,CHARLES H, 1133 COLLEGE, 66502
 537-9030
 22 M 3520 62 PD

DURKEE MD,WILLIAM R, 1133 COLLEGE AVE, 66502
 776-4744
 23 M 1902 45 IM

FAIRCHILD MD,JOHN A, 756 COLLEGE HTS CIR, 66502
 14 M 3006 46 OO

FISCHER MD,REX R, 1133 COLLEGE, 66502
 776-1400
 34 M 3005 68 OBG

FREEMAN MD,FRED A, 1133 COLLEGE, 66502
 537-8710
 42 M 1902 70 U

GARDNER MD,JAMES D, 1133 COLLEGE, 66502
 537-4940
 43 M 2834 76 IM

HANCOCK MD,DANIEL E, 1133 COLLEGE PO BOX 128, 66502
 539-5363
 45 M 2803 78 PATH

HAUN MD,RUDY T, 1133 COLLEGE BLDG D, 66502
 537-8611
 49 M 1902 82 OBG

HEASTY MD,ROBERT G, 2030 SCHEU DR, 66502
 11 M 3519 46 OO

HENNING JR MD,HAROLD J, 1133 COLLEGE, 66502
 55 M 1902 OBG

HINKIN MD,DOUGLAS P, 2900 AMHERST, 66502
 776-9761
 53 M 1902 84 FP

JONES MD,WILLIAM T, 2600 ANDERSON, 66502
 537-4200
 50 M 1902 85 ORS

JUBELT MD,HILBERT P, 426 WESTVIEW DR, 66502
 19 M 1611 49 OO

KIRK MD,THOMAS E, 1133 COLLEGE, 66502
 776-3451
 44 M 3005 76 OPH

KLOBASA MD,CHARLES L, 217 SOUTHWIND PL, 66502
 539-5337
 49 M 2803 80 CHP

LAFENE MD,BENJAMIN W, 1844 ANDERSON, 66502
 01 M 3806 33 OO

LOWE MD,STANLEY W, 1133 COLLEGE, 66502
 776-3451
 32 M 1902 63 OPH

LYONS JR MD,FRANK C, 1133 COLLEGE, 66502
 539-7641
 44 M 3840 74 DR

MARTIN MD,DANIEL C, LAFENE HLTH CTR KSU, 66506
 532-6544
 30 M 1902 59 IM

MCKNIGHT MD,DAVID E, 1133 COLLEGE, 66502
 539-7641
 32 M 1902 63 R

MCNEIL MD,ELBERT D, 1133 COLLEGE, 66502
 537-9030
 22 M 702 49 PD

MOWRY MD,GERALD L, 1441 ANDERSON, 66502
 776-1400
 26 M 1902 53 OBG

OLNEY MD,ROBERT D, 1133 COLLEGE, 66502
 539-7555
 27 M 3005 59 GS

PETERSON MD,JACK T, 1133 COLLEGE, 66502
 539-5363
 25 M 1902 50 PATH

PHILIPP MD,JOSEPH THEODORE, 1133 COLLEGE BLDG D, 66502
 537-7373
 45 M 1902 72 OPH

ROSE MD,GRAHAM C, 1133 COLLEGE, 66502
 537-9030
 46 M 4706 74 PD

SHEFFIELD MD,MICHAEL A, 1133 COLLEGE, 66502
 539-7641
 55 M 1902 86 DR

SHIELDS MD,THOMAS M, 1133 COLLEGE, 66502
 539-5341
 49 M 1902 77 GPVS

STONE MD,G REX, 360 WILDCAT CREEK RD, 66502
 537-7674
 29 M 1902 54 OO

TAYLOR MD,BARBARA D, 1133 COLLEGE, 66502
 357-4940
 50 F 1902 79 IM

TIEMANN MD,WILLIAM H, 1133 COLLEGE, 66502
 537-4940
 42 M 3005 73 FP

VOLKMANN II MD,HARLEY W, 1133 COLLEGE, 66502
 539-7641
 47 M 1902 73 R

MANKATO — 913

(Republic County Medical Society)

KIMBALL MD,RICHARD R, 102 S CENTER, 66956
 378-3511
 45 M 1001 73 FP

MARYSVILLE — 913

(Northeast Kansas Medical Society)

KIMBALL MD,RICHARD R, 808 N 19TH, 66508
 45 M 1001 73 FP

KITOWSKI MD,THEODORE L, 708 N 18TH, 66508
 562-2311
 45 M 84 DR

MCLOUTH — 913
(Shawnee County Medical Society)

SNOOK MD, ROBERT RUFUS, , 66054

11 M 1902 42 OO

MCPHERSON — 316
(McPherson County Medical Society)

BILLINGS MD, THOMAS, PO BOX 1327, 67460
 241-5500
 39 M 1902 67 FP

BRANDSTED MD, ERNEST C, 400 W 4TH, 67460
 241-1654
 18 M 1606 47 OBG

CABRERA MD, ALBERTO, 1425 DOVER RD, 67460
 697-2155
 30 M 74801 80 GS

CLAASSEN MD, SAMUEL D, 400 W FOURTH, 67460
 241-7033
 53 M 1902 79 IM

COLLIER MD, WILLIAM J, 400 W 4TH, 67460
 241-1766
 25 M 3605 59 GS

DENNIS MD, DAVID T, 400 W FOURTH, 67460
 241-7033
 53 M 1902 IM

FERREE MD, RICHARD ALLAN, 400 W FOURTH, 67460
 241-7400
 51 M 3006 78 FP

FIELDS MD, GALEN W, 333 C - S LAKESIDE DR, 67460
 15 M 1902 49 OO

JOHNSON MD, J RICHARD, 400 W 4TH, 67460
 241-4293
 28 M 1902 55 IM

PIERSON MD, WEIR, 1000 HOSPITAL DR, 67460
 241-1445
 17 M 1902 44 FP

PRICE MD, VAUGHAN C, PO BOX 451, 67460
 05 M 4706 32 GS

THOMAS MD, GREGORY MCQUEEN, 400 W FOURTH, 67460
 241-7400
 47 M 1902 79 FP

MEADE — 316
(Iroquois County Medical Society)

FELDMAYER MD, SEELEY T, PO BOX 1030, 67864
 873-5432
 46 M 74811 81 GP

HILL MD, RICHARD H, 234 EAST CARTHAGE, 67864
 873-2113
 18 M 1902 44 FP

MEDICINE LODGE — 316
(Ninnescah Medical Society)

HOFFER MD, JOHN G, 910 N WALNUT, 67104

13 M 1902 44 OO

STUCKY MD, DEAN E, 901 N WALNUT, 67104
 886-5653
 33 M 1902 61 FP

MINNEAPOLIS — 913
(Saline County Medical Society)

BARKER MD, STEVEN E, 311 N MILL, 67467
 392-2144
 51 M 1902 77 FP

WEDEL MD, ALAN K, 311 N MILL, 67467
 392-2144
 56 M 1902 86 FP

WEDEL MD, KENNETH D, 311 N MILL, 67467
 392-2144
 32 M 1902 61 FP

WEDEL MD, KERMIT G, 311 N MILL, 67467
 392-2144
 32 M 1902 61 FP

MINNEOLA — 316
(Iroquois County Medical Society)

STEPHENS MD, CHARLES, MINNEOLA CLINIC, 67865
 885-4202
 33 M 2803 60 FP

MOUNDRIDGE — 316
(McPherson County Medical Society)

KAUFMAN MD, WILLARD E, PO BOX 640, 67107
 345-6322
 28 M 1902 53 FP

LOGANBILL MD, VARDEN J, PO BOX 640, 67107
 345-6322
 26 M 1902 54 FP

MULVANE — 316
(Sedgwick County Medical Society)

COBB MD, LESLIE H, 102 E MAIN, 67110
 777-0101
 17 M 4804 49 FP

NEODESHA — 316
(Southeast Kansas Medical Society)

BARRETT MD, BRADLEY H, RR 2 BOX 260, 66757
 325-3055
 57 M 1902 FP

CHRONISTER MD, BERT, PO BOX 118, 66757
 325-2622
 38 M 1902 65 FP

MOORHEAD JR MD, F ALLEN, 709 MAIN ST, 66757
 325-2200
 39 M 1902 66 FP

NESS CITY — 913
(Central Kansas Medical Society)

IMSEIS MD, MIKHAIL Y, 722 E LOCUST, 67560
 798-2203
 50 M 33004 GP

PRAKALAPAKORN MD, YANYONG, 412 N TOPEKA, 67560
 798-2233
 43 M 89101 78 GS

NEWTON — 316 *(Harvey County Medical Society)*

ALLEN MD,FRANCES A, 1112 BOYD, 67114
15 F 1902 43 OO

BATES MD,MICHAEL N, 215 S PINE STE 302, 67114
283-4153
50 M 1902 77 OBG

BELLOWS-BLAKELY MD,DAVID S, 1901 E FIRST, 67114
283-2400
51 M 1902 P

BOGNER MD,PAUL F, 509 QUAIL CREEK, 67114
283-2800
52 M 1902 80 GS

BOLT MD,MICHAEL, AXTELL CL 203 E BROADWAY, 67114
283-2800
51 M 1902 77 GS

CARPER MD,IVAN H, 203 E BROADWAY, 67114
283-2800
28 M 1902 60 GS

CARPER MD,OWEN E, 203 E BROADWAY, 67114
283-2800
37 M 1902 65 FP

CLAASSEN MD,MILTON A, 201 S PINE ST, 67114
283-3600
32 M 1902 59 ORS

CRAIG MD,CHARLES C, AXTELL CL 203 E BROADWAY, 67114
283-2800
45 M 1902 72 ORS

CROWN MD,STANLEY J, 201 S PINE, 67114
283-3600
56 M 2834 85 FP

DYCK MD,GEORGE, PRAIRIE VIEW INC PO BOX 467, 67114
283-2400
37 M 6201 73 P

ENNS MD,EUGENE K, 6 INDIAN LN, 67114
15 M 1902 40 OO

FENT MD,LEE S, MED ARTS BLDG 316 OAK, 67114
283-0505
14 M 2834 44 GS

FRANSEN MD,HERBERT, 215 S PINE STE 102, 67114
283-0033
32 M 6501 66 GS

FRANSEN MD,PAUL H, 209 S PINE, 67114
283-5040
46 M 6501 74 FP

GLOVER MD,RICHARD M, AXTELL CL 203 E BROADWAY, 67114
283-2800
21 M 1902 53 FP

GRABER MD,CHARLES, 215 S PINE STE 102, 67114
283-0033
44 M 3006 78 GS

GRISWOLD MD,DALE G, AXTELL CL 203 E BROADWAY, 67114
283-2800
27 M 1902 53 IM

HENDRICKSON MD,JON R, AXTELL CL 203 E BROADWAY, 67114
283-2800
51 M 1902 80 PD

HENDRICKSON MD,KATHRYN D, AXTELL CL 203 E BROADWAY, 67114
283-2800
52 F 1902 80 PD

IRWIN MD,RICHARD L, 218 S KANSAS, 67114
283-1400
48 M 1902 79 OPH

ISAAC MD,CHARLES A, 203 E BROADWAY, 67114
283-2800
25 M 1902 49 U

KLIEWER MD,VERNON L, PO BOX 467, 67114
283-2400
31 M 1606 58 CP

KUMAR MD,SURINDER, 201 S PINE, 67114
283-3600
46 M 1902 78 OBG

LINDHOLM MD,GERALD R, AXTELL CL 203 E BROADWAY, 67114
283-2800
51 M 1902 78 FP

MORGAN MD,SCOTT, 201 S PINE, 67114
883-3600
00 M IM

NACHTIGALL MD,ANDREW, BETHEL CL 201 S PINE, 67114
283-3600
28 M 1902 64 PD

OLSON MD,ERWIN T, BETHEL CL 201 S PINE, 67114
283-3600
19 M 1902 47 PD

PRENTISS MD,HAROLD, 1305 TERRACE DR, 67114
283-9433
36 M 1720 77 R

QAMAR MD,YUSUF, 203 E BROADWAY, 67114
283-2800
38 M 70409 70 IM

RADOVANOV MD,RADMILA, BOX 364, 67114
286-1130
34 F 95702 72 R

RICH MD,ELDON S, PO BOX 277, 67117
16 M 1902 46 OO

SCHMIDT MD,HERBERT R, 413 SE 10TH ST., 67114
03 M 1902 34 OO

SILLS MD,CHARLES T, 1631 HILLCREST, 67114
09 M 1902 37 OO

SIMMONS MD,ROBERT EARLE, 209 S PINE, 67114
283-5040
49 M 1902 76 IM

STEVENS MD,RONALD, 201 S PINE, 67114
883-3600
49 M 64914 87 FP

TANDOC JR MD,VALENTIN T, BETHEL CL 201 S PINE, 67114
283-3600
39 M 74809 74 U

VOGT MD,VERNON W, BETHEL CL 201 S PINE, 67114
283-3600
22 M 3005 55 FP

WHEELER MD,DWIGHT E, 201 S PINE, 67114
283-3600
50 M 2012 79 IM

WIENS MD,J WENDELL, 201 S PINE, 67114
283-3600
32 M 1902 60 GS

NORTON — 913 *(Northwest Kansas Medical Society)*

COLIP MD,F MERLYNN, 711 N NORTON, 67654
877-3305
35 M 1902 63 FP

COOPER MD,ARTHUR E, 307 W WILBERFORCE, 67654
08 M 1611 36 GP

HARTMAN MD,ROGER L, 711 N NORTON, 67654
877-3305
35 M 1902 65 FP

LONG MD,ROBERT C, 711 N NORTON, 67654
927-3305
27 M 1902 53 GS

NORTONVILLE — 913
(Atchison County Medical Society)

MADISON MD, WILLARD A, BOX 68, 66060

20 M 1902 51 OO

OAKLEY — 913
(Northwest Kansas Medical Society)

ADAMS MD, ALAN W, 123 CENTER AVE BOX 756, 67748

672-3261
54 M 1902 81 FP

OHMART MD, RICHARD V, PO BOX 756, 67748

672-3262
36 M 1902 63 FP

SEKAVEC MD, GORDON B, 525 FREEMAN, 67748

07 M 1902 38 OO

OBERLIN — 913
(Northwest Kansas Medical Society)

PALMER MD, MARGUERITE L, BOX 110, 67749

475-2221
25 F 5404 76 GP

SIMPSON MD, ROBERT LIMBAUGH, 902 W COLUMBIA, 67749

475-2221
25 M 4706 77 GS

WHITAKER MD, REN R, 902 W COLUMBIA, 67749

475-2222
37 M 5404 70 FP

OLATHE — 913
(Johnson County Medical Society)

ARONOFF MD, MICHAEL E, 407 S CLAIRBORNE STE 209, 66062

782-3953
39 M 1604 73 OTO

BEEBE MD, EDMER, 420 E CEDAR, 66061

03 M 5605 33 OO

BLUM D.O., MICHAEL A, 401 S CLAIRBORNE STE 200, 66062

764-7060
47 M 2878 77 PD

DELPHIA MD, ROBERT E, 401 S CLAIRBORNE, 66062

782-1610
24 M 1902 56 FP

ELLIS MD, S CHRISTOPHER, 300 S ROGERS RD, 66061

791-4220
47 M 85 ANES

FORTUNE MD, CEDRIC B, PO BOX 910, 66061

782-3322
40 M 1902 67 FP

GLAZZARD MD, CHARLES D, 407 S CLAIRBORNE STE 208, 66062

782-3384
28 M 2507 65 P

HALVORSON MD, HOWARD C, 407 S CLAIRBORNE STE 104, 66062

782-2020
41 M 5404 75 U

HUDSON MD, ROBERT P, 12925 FRONTIER RD, 66061

588-7040
26 M 1902 52 IM

JENSEN MD, THOMAS M, 407 S CLAIRBORNE SUITE 101, 66062

782-1148
47 M 3005 75 ORS

LAIRD MD, DALE D, 151 W 151ST #100, 66061

782-3631
42 M 1902 69 OPH

MACFARLANE MD, DOUGLAS B, 405 CLAIRBORNE STE 2, 66062

782-3073
54 M 1902 81 OBG

MATTHEW MD, WILLIAM L, 405 S CLAIRBORNE, 66061

782-3322
29 M 1902 56 FP

MCCANN MD, WILLIAM E, PO BOX 8, 66061

22 M 3901 53 OO

MEE MD, ADRIAN W, 28 HOLLY DR, 66062

791-4220
19 M 1902 54 ANES

MENDLICK MD, R MICHAEL, 407 S CLAIRBORNE STE 101, 6606

782-1148
44 M 1902 71 ORS

MORGAN II MD, DAVID LLOYD, 807 S CLAIRBORNE, 66062

782-8300
49 M 2820 75 IM

NIXON MD, LINDA K, 401 S CLAIRBORNE, 66062

764-7060
57 F 1902 86 PD

NIXON MD, LINDA K, 540 EAST SANTA FE, 66061

782-0260
57 F 1902 86 PD

RIEDERER MD, ROBERT E, 500 E CEDAR, 66061

829-3822
16 M 1902 42 OO

ROMONDO MD, STEVEN A, 215 W 151ST, 66061

791-4220
47 M 1902 75 ANES

RUHLEN MD, JAMES L, 807 S CLAIRBORNE, 66062

782-8300
46 M 1902 73 IM

SEAMAN MD, LAUREN I, 1613 E SHERIDAN, 66062

07 M 6001 68 OO

SHANKER MD, STUART G, 401 S CLAIRBORNE STE 200, 66062

764-7060
49 M 2803 78 PD

SHEFFER MD, KEITH D, 407 S CLAIRBORNE STE 101, 66062

782-1148
37 M 1720 74 ORS

SNYDER MD, RICHARD HENRY, 215 W 151ST, 66061

791-4220
45 M 1902 75 ANES

STANDLEE MD, TIM E, 215 W 151ST, 66061

791-4220
56 M 1902 85 ANES

ONAGA — 913
(Pottawatomie County Medical Society)

WALSH MD, THOMAS E, ONAGA CLINIC, 66521

889-4241
48 M 1902 75 FP

OSAGE CITY — 913
(Flint Hills County Medical Society)

ADAMS MD, DWIGHT, 608 HOLLIDAY, 66523

528-3161
00 M 1902 56 GP

OSAWATOMIE — 913
(Miami County Medical Society)

APPENFELLER MD, WILLIAM O, 524 BROWN AVE, 66064
755-3166
25 M 1902 53 FP

BILLINGSLEY JR MD, JOHN A, PO BOX 500 C/O OSAWATOMIE HOSP,
755-3151 66064
31 M 1902 59 ADT

OSWEGO — 316
(Labette County Medical Society)

BURGESS MD, ARTHUR P, PO BOX 126, 67356
19 M 1902 52 OO

OTTAWA — 913
(Franklin County Medical Society)

HADLEY MD, DELMONT C, 1320 S ASH, 66067
242-3891
35 M 1902 65 FP

HENNING MD, CALVIN W, PO BOX 2, 66067
05 M 1902 35 OO

REYES JR MD, FRANCISCO A, 1320 S ASH, 66067
242-5312
38 M 74801 74 GS

SPEER MD, LOUIS N, PO BOX D, 66067
242-1257
14 M 1606 41 FP

OVERBROOK — 913
(Flint Hills Medical Society)

RUBLE JR MD, JAMES L, OVERBROOK COMM CLINIC, 66524
665-2205
26 M 1902 53 FP

PAOLA — 913
(Miami County Medical Society)

BANKS MD, ROBERT E, PO BOX 298, 66071
294-2305
29 M 1902 55 FP

ROWLETT MD, JACK G, PO DRAWER A, 66071
294-2356
21 M 1902 52 FP

STANLEY MD, REX C, PO DRAWER A, 66071
294-2056
24 M 1902 52 GS

PARSONS — 316
(Labette County Medical Society)

AVES MD, AGNES, 1509 MAIN, 67357
421-0600
38 F 74801 72 IM

AVES MD, RENATO B, 1509 MAIN, 67357
421-0600
35 M 74801 72 GS

CAREY MD, LARRY J, 400 KATY, 67357
421-8361
51 M 1902 78 FP

CRAMER MD, GUY W, 412 MURDOCK, 67357

11 M 1902 39 OO

DAIZ MD, ANTONIO S, PO BOX 935, 67357

421-0091
37 M 74810 80 DR

DILLON MD, WILLIAM L, LABETTE CO MED CL BOX H, 67357

421-0881
45 M 1902 73 ORS

EDROZO MD, M LUZ LUNA, 2601 GABRIEL, 67357

421-6550
44 F 74801 76 PATH

KISHORE MD, ROY N, PO BOX 238, 67357

421-4062
44 M 49511 80 OTO

KISHORE MD, SHEELA, 2907 JOHNSON RD, 67357

421-2741
43 F 49511 74 ANES

LAVA MD, CHIRUND, PO BOX 290, 67357

421-6210
40 M 89102 76 GS

MILLER MD, CHARLES H, 2819 CLARK, 67357

07 M 3006 32 OO

MILLER MD, DEAN M, 203 CRESTVIEW, 67357

421-4880
22 M 1902 48 R

MILLER MD, STEPHEN FRANCIS, 1509 MAIN, 67357

421-0600
45 M 1902 72 GS

PACE MD, JOHN D, KATY HOSP PO BOX 1157, 67357

94 M 1902 20 FP

PAI MD, RADHA V, PO BOX 1057, 67357

421-0080
45 F 6701 78 ANES

PAI MD, VARADARAJ S, PO BOX 1057, 67357

421-0080
42 M 6701 78 U

PARANJOTHI MD, SUBRAMONIAM P, 1509 MAIN, 67357

421-6160
39 M 49531 74 IM

PAULS MD, DANIEL N, PO BOX 1014, 67357

421-1431
45 M 1902 72 IM

POLLMAN MD, STANLEY E, PO BOX 1394, JOPLIN, MO 68402

417-623-0744
30 M 3007 84 PATH

ROTHSTEIN MD, TERRY B, PO BOX B, 67357

421-5900
43 M 1606 76 OPH

SHARMA MD, ARUN L, 1509 MAIN, 67357

421-0600
46 F 49503 77 FP

TANANUNKUL MD, URAIWAN, PO BOX 256, 67357

421-2460
51 M 89101 PD

TANG MD, CHANTRA, PO BOX 1054, 67357

421-2460
47 F 89104 82 PD

TANG MD, SAROHD, PO BOX 1054, 67357

421-2460
43 M 89102 76 OBG

VERMA MD, ASHA, 400 KATY, 67357

421-9090
37 F 49530 76 PD

PITTSBURG — 316
(Crawford-Cherokee County Medical Society)

ARMSTRONG MD, HAROLD J, PROFESSIONAL BUILDING, 66762

232-2600
40 M 1902 69 ORS

BENA MD,JAMES, 405 WEBSTER, 66762
12 M 3005 38 OO

BERKEY MD,VERNON A, NATL BANK BLDG, 66762
231-7650
18 M 1902 43 R

BIERLEIN MD,KENNETH J, 812 S CATALPA, 66762
06 M 1606 33 OO

COOMER MD,TYLER E, 315 NATL BANK BLDG, 66762
231-7730
30 M 2101 65 GS

COPELAND MD,JACK L, 1015 MT CARMEL PL, 66762
231-5900
53 M 3901 83 IM

ERICKSON MD,CLARENCE W, 217 NATL BANK BLDG, 66762
231-7400
06 M 1902 33 IM

ESCH MD,JOHN G, PO BOX 1133, 66762
24 M 3006 56 OO

FREEMAN MD,MALCOLM C, 1102 VILLAGE DR, 66762
231-6100
44 M 35207 80 ANES

GOMETZ MD,MODESTO S, PO BOX 1746, 66762
231-2490
35 M 72601 71 PD

HOLSINGER MD,DONALD M, 1015 MT CARMEL PL, 66762
231-5900
38 M 1902 65 IM

HUEBNER MD,ROBERT STEPHAN, NAT'L BANK BLDG 4TH & BROADWAY,
231-6160 66762
42 M 1606 78 GS

HUERTER MD,DAVID F, 909 CENTENNIAL, 66762
231-1650
46 M 1902 75 IM

LANCE MD,RAYMOND W, 608 W QUINCY, 66762
22 M 1902 47 OO

LEFFLER MD,PAUL B, 309 WINWOOD, 66762
02 M 1902 40 OO

LEFFLER MD,PAUL B, 909 CENTENNIAL, 66762
02 M 1902 40 OO

MILLER MD,EARL E, 1312 S BROADWAY, 66762
231-6410
13 M 1902 37 ENT

MULLER MD,SAMUEL B, 611 W QUINCY, 66762
05 M 1902 34 OO

NEWMAN MD,CLIFFORD B, 1204 E 7TH, 66762
01 M 1902 28 OO

ODGERS MD,RODNEY K, 909 CENTENNIAL, 66762
231-4300
00 M 1902 75 IM

PAPP JR MD,S DEAN, R 5 BOX 293, 66762
231-7650
46 M 1902 80 DR

POGSON MD,GEORGE W, 1015 MT CARMEL PL, 66762
231-5900
24 M 1902 47 IM

RAMIREZ MD,AUGUSTO H, 909 CENTENNIAL, 66762
231-1600
32 M 26407 74 IM

RAMIREZ MD,IRENE, 909 CENTENNIAL, 66762
231-6280
00 F 74 PD

RUMINSON MD,RONALD R, MT CARMEL MED CTR EM, 66762
231-6100
49 M 64914 86 EM

SCHLEMMER MD,ROGER B, 1003 S BROADWAY, 66762
231-6380
37 M 1902 68 OPH

SEGLIE MD,FLOYD RONALD, 909 CENTENNIAL STE 3, 66762
231-6280
43 M 1902 70 FP

TAWIL MD,ELIAS ADIB, 2701 S ROUSE, 66762
231-0850
52 M 33004 83 U

TWEET MD,FREDRICK A, RR 5 BOX 196, 66762
231-6100
39 M 1602 68 PATH

YAGHMOUR MD,TALAAAT E, 2701 S ROUSE, 66762
231-0850
40 M 33002 72 U

ZABEL MD,KENNETH P, 909 CENTENNIAL, 66762
231-1650
37 M 1902 66 IM

PLAINVILLE — 913 *(Central Kansas Medical Society)*

KELLERMAN MD,RICK, 409 S COCHRAN, 67663
434-4609
00 M 1902 81 FP

PEDERSON MD,ARNOLD M, 300 COLORADO, 67663
434-4609
22 M 1902 51 FP

PLEASANTON — 913 *(Bourbon County Medical Society)*

JUSTUS MD,WILLIAM J, PO BOX 407, 66075
352-6134
29 M 1902 55 FP

MANGLER MD,VICTOR R, 900 MAIN BOX 524, 66075
352-8943
56 M 1902 85 FP

PRATT — 316 *(Ninnescah Medical Society)*

AMBLER MD,CARL D, PO BOX 364, 67124
672-6476
31 M 1902 57 R

BARKER MD,PATRICK N, 420 COUNTRY CLUB RD, 67124
672-7411
45 M 1902 72 GS

BLACK MD,CYRIL V, RR 2, 67124
05 M 4802 31 OO

DILLON MD,STEVEN C, 420 COUNTRY CLUB RD, 67124
672-7411
53 M 1902 82 IM

FILLEY MD,VERNON W, LAKE ROAD, 67124
13 M 3005 49 OO

FREEMAN MD,F GILES, PO BOX 1044, 67124
672-5555
18 M 1902 44 FP

MASON MD,ROGER, 420 COUNTRY CLUB RD, 67124
672-7411
00 M 84 GS

PAULY MD,TIMOTHY R, 420 COUNTRY CLUB RD, 67124
672-7422
56 M 1902 85 FP

ROSEN MD,CARL H, 420 COUNTRY CLUB RD, 67124
672-7411
46 M 4812 84 U

SUITER MD,DANIEL JAY, 420 COUNTRY CLUB RD, 67124
672-7411
44 M 1902 74 GE

THORPE MD,FRANCIS A, 2 LAKE RD, 67124
672-5555
08 M 1606 37 OO

VARADHAN MD,JANAKI, 420 COUNTRY CLUB RD, 67124
672-7411
45 F 49533 86 GPVS

WARD MD,ROBERT L, 1219G E FIRST, 67124
672-6220
24 M 1902 52 FP

WITTMAN MD,A T, 310 E 2ND, 67124
672-5555
00 M 87 GS

WOLFF MD,FREDERICK P, PO BOX 1044, 67124
672-5555
20 M 1902 44 IM

PROTECTION — 316 (Iroquois County Medical Society)

GLENN MD,LYLE G, 146 BROADWAY BOX 447, 67127
12 M 1606 40 OO

QUINTER — 913 (Northwest Kansas Medical Society)

HIESTERMAN MD,HERMAN W, QUINTER CL BLDG 116 E 4TH, 67752
754-3333
23 M 1902 51 FP

RANSOM — 913 (Central Kansas Medical Society)

MCLAIN MD,KENNETH, BOX 247, 67572
731-2295
21 M 1902 46 FP

RUSSELL — 913 (Central Kansas Medical Society)

MERKEL MD,EARL D, SHIELDS BLDG 326 N MAIN, 67665
483-2178
32 M 1902 57 FP

PANICHABHONGSE MD,SAMBHUNDH, 213 WEST 7TH, 67665
483-2133
43 M 89101 76 GS

PETTIJOHN MD,WALTER J, 624 W 12TH, 67665
12 M 1902 37 OO

STARKEY MD,JERALD L, 326 MAIN, 67665
483-2178
30 M 1902 56 FP

SWANN MD,CLAIR L, 112 W SIXTH, 67665
483-4212
13 M 1902 39 IM

WHITE MD,FAGAN N, 356 W 5TH, 67665
11 M 702 37 OO

SABETHA — 913 (Northeast Kansas Medical Society)

KENNALLY MD,KEVIN P, 1115 MAIN, 66534
284-2141
53 M 1902 81 FP

MONTGOMERY MD,THOMAS ALLEN, 1013 WYOMING, 66534
10 M 1902 49 OO

WENGER MD,GREGG D, 1115 MAIN, 66534
284-2141
00 M 1902 81 PD

YULICH MD,JOHN O, PO BOX 227, 66534
284-2125
33 M 1902 61 FP

SALINA — 913 (Saline County Medical Society)

ALLEN MD, MONTE L, 600-E SOUTH SANTA FE, 67401
827-0307
36 M 1902 62 OTO

ALSOP MD,WILLIAM R, PO BOX 260, 67402
827-7261
52 M 78 GE

ANDERSON MD,JODY, PO BOX 260, 67402
827-7261
32 F 1902 64 IM

BAXTER MD,W REESE, PO BOX 1847, 67402
825-8221
47 M 1902 74 FP

BELL MD,MARK G, 909 E WAYNE, 67401
823-7225
50 M 1902 77 ENT

BOSSEMEYER II MD,CHARLES H, PO BOX 1672, 67402
825-8221
49 M 1902 84 FP

BROWN MD,ROBERT WAYNE, PO BOX 1757, 67402
825-7251
23 M 1902 55 IM

BRUNGARDT MD,BERNARD A, 400 E BELOIT, 67401
21 M 3006 46 OO

BYERS MD,JONELL, PO BOX 260, 67402
827-7261
53 F 1902 79 D

CATHCART-RAKE MD,WILLIAM F, BOX 260, 67402
827-0260
48 M 1902 75 IM

CLARK MD,DAVID H, PO BOX 1847, 67402
825-8221
36 M 1902 63 FP

COFFEY MD,ROY B, 762 VICTORIA HEIGHTS TERR, 67401
24 M 1902 47 OO

CONNER MD,BRIAN, 1518 B EAST IRON, 67401
825-2020
46 M 1902 73 OPH

COOPER MD,JAMES L, PO BOX 2027, 67402
823-7201
56 M 1902 83 PATH

COSSETTE MD,JERROLD E, 909 E WAYNE, 67401
823-7225
46 M 1902 76 ENT

CULTRON MD,FRANK T, 837 D FAIRDALE RD, 67401
10 M 1643 47 OO

D'SOUZA MD,BISMARCK C, PO BOX 2327, 67402
827-9526
45 M 49501 78 R

DOWELL MD,JAMES C, 645 E IRON, 67402 827-7255 26 M 1611 53 IM	JACKSON JR MD,DELMAS A, 645 E IRON, 67402 827-7255 35 M 2101 65 IM
DRAEMEL MD,H RICHARD, 2203 EDGEHILL RD, 67401 827-0307 18 M 1902 53 OTO	KREHBIEL MD,MARK A, PO BOX 1847, 67402 825-8221 49 M 1902 76 FP
DREHER MD,HENRY S, PO BOX 260, 67402 827-7261 18 M 1902 43 IM	KRUCKEMYER MD,ALAN L, 645 E IRON, 67401 823-2215 45 M 1103 77 ORS
EATON MD,GLEN E, 4353 E NORTH, 67401 827-3064 28 M 1902 54 ANES	LAWRENCE MD,GILBERT A, 116-A S SEVENTH, 67401 827-9526 47 M 49501 83 R
EATON MD,LESLIE F, RR 1 BOX 346, 67401 06 M 1902 34 OO	LAWRENCE MD,LINDA M, 929 ELMHURST, 67401 823-1600 57 F 4802 86 OPH
ELLISON MD,PAUL D, 1499 E IRON, 67401 825-7271 35 M 2105 67 OPH	LISTERMAN MD,JOHN C, PO BOX 1757, 67402 825-7251 42 M 2803 83 FP
FEIGHNY MD,ROBERT E, 2437 VILLAGE, 67401 20 M 1902 51 OO	LIVINGSTON MD,CHARLES E, 400 E IRON, 67401 823-9166 32 M 1611 64 GS
FERGUSON DO,ELAINE L, 2033 RAYMOND, 67401 825-5717 00 M IM	MACY MD,NORMAN E, PO BOX 2027, 67402 827-4053 35 M 1902 64 PATH
FRANCIS MD,ANTHONY E, 519 S SANTA FE, 67401 827-4424 54 M 1902 82 ORS	MACY MD,TED L, PO BOX 260, 67402 827-7261 43 M 1902 73 GS
FREEMAN MD,RAYMOND S, 1901 E IRON, 67401 20 M 702 59 OO	MANGUOGLU MD,ALI B, 523 S SANTA FE, 67401 823-1032 53 M 90205 85 N
GANS MD,FREDERICK A, 950 S ELEVENTH, 67401 22 M 2834 51 OO	MARCHBANKS MD,DONALD L, 520 COUNTRY CLUB RD, 67401 24 M 1902 51 OO
GRIFFING MD,RICHARD B, PO BOX 2606, 67402 827-3294 00 M 1902 ANES	MARSHALL MD,GEORGE W, PO BOX 1845, 67402 825-8191 44 M 1902 71 OBG
GRIFFITH MD,FRANK H, 1493 E IRON, 67401 827-0488 45 M 4813 76 OPH	MARTIN MD,OLIVER L, 715 E REPUBLIC, 67401 08 M 1902 38 OO
GUNN MD,MARVIN R, PO BOX 2327, 67402 827-9526 28 M 3901 63 R	MATTHEWS MD,EARL H, 135 E CLAFLIN, 67401 827-9631 49 M 1902 78 GS
GUZMAN MD,MANUEL, CKMHC 809 ELMHURST, 67401 823-6322 27 M 64901 69 P	MAXWELL MD,GORDON E, 135 E CLAFLIN, 67401 827-9631 29 M 1902 55 OBG
HARBIN MD,GARY LYNN, 523 S SANTA FE, 67401 823-7213 50 M 1902 77 ORS	MCCRAE MD,SPENCER C, 655 GUERNSEY DR, 67401 18 M 3509 52 OO
HARRIS MD,NORMAN R, 833 ELMHURST PO BOX 138, 67402 827-1533 30 M 1902 63 OBG	MILLER MD,ELDEN V, 1928 RIDGELEA, 67401 19 M 1902 44 OO
HASSLER MD,RANDY D, 645 E IRON, 67401 827-9635 45 M 1902 78 U	MOWERY MD,WILLIAM E, PO BOX 260, 67402 827-7261 23 M 1902 47 GS
HATTON MD,LLOYD W, 709 HIGHLAND, 67401 06 M 1902 33 OO	NEUMANN MD,JAMES W, 600-E SOUTH SANTA FE, 67401 825-5041 24 M 1902 83 N
HERRMAN MD,ADAM L, 519 S SANTA FE, 67401 827-4424 48 M 1902 82 ORS	NICKELL MD,WENDELL K, 400 E IRON, 67401 823-9166 26 M 1606 51 TS
HODGES MD,MERLE A, PO BOX 1845, 67402 825-8191 34 M 1902 66 OBG	NIXON MD,RICHARD R, BOX 2327, 67402 827-9526 32 M 1643 65 R
HOLMAN MD,JON B, PO BOX 61, 67401 827-9366 33 M 1902 64 P	NULL MD,WILLIAM G, 135 E CLAFLIN, 67401 827-9631 31 M 102 66 PD
HOUSE MD,R E, PO BOX 2327, 67401 827-9526 54 M 1902 82 DR	OBANDO MD,GUILLERMO, 2110 KNOLLCREST DR, 67401 827-7261 35 M 26404 74 R
HUNNINGHAKE MD,RONALD, PO BOX 1847, 67402 825-8221 51 M 1902 82 FP	PALMER MD,GERALD K, PO BOX 2027, 67402 823-7201 24 M 1803 61 PATH

PETERSON MD,JAMES E, PO BOX 2327, 67402
827-9526
53 M 1902 82 DR

REECE MD,RICHARD J, 502 BEECHWOOD, 67401
23 M 1902 49 OO

RICHARDS DO,DOUGLAS C, 430 S OHIO, 67401
827-0346
47 M 2878 FP

RICHARDS MD,JON F, 135 E CLAFLIN, 67401
827-9631
50 M 1902 IM

RODERICK MD,JAMES E, 645 E IRON, 67401
827-9635
23 M 1902 47 U

ROMEISER MD,REX S, 645 E IRON, 67401
827-9635
41 M 1902 68 U

ROSALES MD,J EDGAR, 737 E CRAWFORD, 67401
827-7261
00 M PD

RUEB MD,ANDREW E, 841 FAIRDALE RD #A, 67401
11 M 1606 36 OO

SCHMIDT MD,RAMON WARNER, 400 E IRON, 67401
823-9166
39 M 1902 66 GS

SCOTT MD,CHESTER E, 519 S SANTA FE, 67401
827-5549
23 M 1902 51 FP

SEATON MD,ROBERT D, PO BOX 260, 67402
827-7261
00 M 83 NEP

SEBREE MD,STEVEN G, PO BOX 260, 67401
827-7261
47 M 1902 74 OBG

SLOO MD,MILO G, 645 E IRON, 67401
823-2215
41 M 1902 68 ORS

SMITH MD,BOYD E, BOX 2027, 67402
827-4053
46 M 3005 78 PATH

SMITH MD,DAVID E, PO BOX 260, 67402
827-7261
50 M 1902 77 GS

SMITH MD,HAROLD R, PO BOX 260, 67402
827-7261
19 M 1902 51 GS

STOSKOPF MD,LAWRENCE E, 2413 EDGEHILL, 67401
823-9498
39 M 1902 73 ANES

STUEWE MD,BRADLEY R, PO BOX 260, 67402
827-7261
49 M IM

TAYLOR MD,THOMAS F, PO BOX 676, 67402
827-0346
26 M 1902 53 FP

WAGENBLAST MD,HOWARD R, PO BOX 260, 67402
827-7261
21 M 1902 49 OO

WATERS MD,CLARENCE N, 833 MANOR RD, 67401
823-6497
13 M 2834 60 OO

WEBER MD,ROBERT W, 645 E IRON, 67402
827-7255
26 M 1902 49 IM

WOODALL MD,DENNIS C, 131 W CLAFLIN, 67470
825-7251
55 M 1902 84 FP

SCOTT CITY — 316 (Southwest Kansas Medical Society)

DUNN MD,DANIEL R, 202 COLLEGE, 67871
872-2187
49 M 1902 75 FP

HOPKINS JR MD,B MORRISON, 202 COLLEGE, 67871
872-2187
23 M 1902 53 FP

SEDAN — 316 (Southeast Kansas Medical Society)

TAYLOR MD,ELMER W, 120 W OSAGE BOX 8, 67361
725-3141
28 M 512 62 FP

WALKER MD,WILLIAM K, 111 E CHEROKEE, 67361
725-3171
18 M 1902 45 FP

SENECA — 913 (Northeast Kansas Medical Society)

BERKLEY MD,NORMAN W, 15 SOUTH 5TH ST, 66538
336-2128
31 M 1902 64 FP

GILBERT MD,J HOWARD, 211 S FOURTH, 66538
05 M 1902 41 OO

SHARON SPRINGS — 913 (Northwest Kansas Medical Society)

CHUNG MD,JOHN J, WALLACE CO MED CL BOX 310, 67758
852-4214
23 M 58301 60 FP

SHAWNEE MISSION — 913 (Johnson County Medical Society)

ALLEN MD,MAX S, 5103 W 96TH TERR, 66207
11 M 1902 37 OO

ALTENBERND MD,ELVIN CONRAD, 7319 W 81ST, 66204
648-2010
26 M 1902 54 FP

ANDERSON MD,WILLIAM A, 2508 W 71ST, 66208
236-7288
50 M 2846 83 EM

ARMBRUSTER MD,ALBERT A, 9119 WEST 74TH STE 302, 66204
362-9220
17 M 512 58 GS

BADEEN II MD, LOUIS JOHN, 10600 QUIVIRA RD #460, 66215
492-3344
49 M 2846 78 OPH

BAEKE MD,JOHN O, 6806 WEST 83RD, 66204
642-4242
19 M 1902 52 FP

BAKER MD,WILLIAM STEVEN, 7700 W 63RD STE 209, 66204
262-1843
47 M 702 76 P

BALANOFF MD,ARNOLD Z, 4601 W 109TH STE 122, 66211
491-4045
42 M 1803 72 PD

BANSAL MD,ROOPA O, 5600 W 95TH STE 105, 66207
381-6765
37 F 49504 80 FP

BANSAL MD,SATISH C, 8901 W 74TH STE 147, 66204 384-2220 38 M 49541 74 ORS	BROOKS MD,WILLIAM HENRY, 2213 W 49TH TERR, 66205 371-4343 49 M 1902 78 R
BAPTIST MD,JEREMY E, 5811 OUTLOOK, 66202 432-0625 40 M 2846 79 A	BROWN MD,WILLIAM R, 7301 MISSION STE 339, 66208 236-8866 23 M 1902 48 IM
BARE II MD,CHARLES E, 8901 W 74TH STE 353, 66204 677-2460 43 M 1902 70 U	BROXTERMAN MD,STEVEN JOSEPH, 9119 W 74TH STE 150, 66204 362-5510 51 M 1902 77 FP
BARKER MD,ELIZABETH B, 4121 WEST 83RD STE 123, 66208 381-6669 30 F 4706 66 P	BRUNING MD,DANIEL LEE, 8901 W 74TH STE 200, 66212 676-2479 56 M 2834 84 ANES
BARKER MD,JAMES BERTON, 8901 W 74TH STE 148, 66204 362-6310 31 M 4706 66 OTO	BRUNING MD,ROGER MARION, 7301 MISSION STE 342, 66208 384-0745 48 M 1902 79 FP
BARNETT JR MD,THOMAS E, 10600 QUIVIRA STE 240, 66215 541-3355 52 M 1902 80 GE	BUBB MD,STEPHEN K, 8901 W 74TH STE 3, 66204 362-0031 48 M 1902 76 ORS
BARNHART MD,RONALD J, 9119 WEST 74TH STE 268, 66204 831-2334 41 M 2501 69 OBG	BUCKMAN MD,MARTIN SPALDING, 10600 QUIVIRA STE 240, 66215 541-3355 49 M 2802 75 IM
BARR MD,RICHARD N, 7301 MISSION STE 119, 66208 432-4366 32 M 1902 57 OPH	BURGER MD,PAUL B, 5638 NIEMAN RD, 66203 631-6114 25 M 2834 50 FP
BARRICK MD,BRUCE, SH MSN MED CTR PO BOX 2923, 66201 676-2340 39 M 1902 66 PATH	BUSER MD,WILLIAM D, 8901 W 74TH STE 372, 66204 491-4019 55 M 1902 83 GE
BATTY MD,LARRY H, 9119 W 74TH STE 268, 66204 831-2334 51 M 1902 77 OBG	CALKINS MD,LARRY L, 5635 SUWANEE, 66205 18 M 1902 43 OO
BAUER MD,LAKE W, 4818 W 80TH, 66208 20 M 1902 49 OO	CASTEEL MD,CHARLES K, 8901 W 74TH STE 357, 66204 831-1003 34 M 3901 64 U
BAUER MD,MARTIN L, 2500 W 71ST, 66205 281-8881 47 M 1902 76 PD	CATTANEO MD,ERNEST A, 9119 W 74TH STE 360, 66204 262-3930 39 M 1902 66 IM
BEEZLEY MD,MICHAEL J, 8800 W 75TH STE 115, 66204 262-9200 47 M 1902 74 GPVS	CEDERLIND MD,CRANSTON JAY, 8901 W 74 STE 36, 66204 236-6455 45 M 1902 72 OBG
BELL MD,DELORIS W, 4601 W 109TH STE 116, 66211 491-6550 42 F 1902 69 OPH	CHIN MD,HONG W, 10500 MASTIN, 66212 492-9729 35 M 58302 86 TR
BELT MD,ROBERT J, 12000 W 110 #400, 66210 469-8023 45 M 702 75 ON	CLENDENIN MD,ROBERT KEELE, BOX 25785, 66225 345-1900 48 M 1902 75 EM
BELZER MD,EDWARD G, 10600 QUIVIRA STE 330, 66215 541-3300 36 M 3005 67 PD	COE MD,RICHARD O, 7301 MISSION STE 247, 66208 362-8505 31 M 4804 62 OPH
BENNETT EXEC SE ,ALLIENE, JOHNSON CO MEDICAL SOC, 66208 432-9444 00 F	COHEN MD,ROBERT A, 3700 W 83RD STE 110, 66208 642-2100 39 M 2803 70 PD
BIKALES MD,VICTOR WILLIAM, 10688 RIGGS DR, 66212 383-1311 13 M 2105 78 P	COLEMAN MD,ROBERT L, 8901 W 74TH STE 1, 66204 362-0100 41 M 4113 79 PS
BILLINGSLEY MD,THAD H, 7000 SQUIBB RD #100, 66202 432-9900 41 M 1902 67 P	COOLEY MD,DAVID A, 8800 W 75TH STE 300, 66204 362-1226 40 M 2802 72 RHU
BISHOP MD,FRANCIS E, 7501 MISSION RD STE N10, 66208 648-3533 20 M 1902 45 P	COOPER MD,JACK R, 5300 MISSION RD, 66205 17 M 3840 52 OO
BISHOP MD,HENRY R, 10600 QUIVIRA STE 320, 66215 541-3200 53 M 4813 82 OBG	CORBIN MD,MURRAY D, 10550 QUIVIRA RD-5TH FL, 66215 492-6200 39 M 1902 66 CD
BLETZ MD,DONALD B, 10550 QUIVIRA STE 510, 66215 492-6200 28 M 5104 72 IM	COULTER MD,HENRY F, 4203 W 151 ST, 66224 23 M 1902 51 OO
BOLES MD,J MICHAEL, 5949 NIEMAN, 66203 631-1300 35 M 1902 62 FP	COULTER MD,THOMAS B, 8800 W 75TH STE 310, 66204 677-3113 38 M 1205 72 OPH
BRAVERMAN MD,DAVID ELLIOTT, 4601 W 109TH STE 330, 66211 491-9123 47 M 2507 77 PDO	

COX JR MD,IRA, 5829 WOODSON PO BOX 975, 66201 722-1100 19 M 1902 49 FP	GALLEHUGH MD,KEITH W, 9027 BIRCH, 66207 371-4343 32 M 1902 57 R
CRIE MD,JOHN S, 10550 QUIVIRA STE 510, 66215 492-6200 49 M 4812 83 CD	GARCIA MD,FRANCISCO, 8020 SANTA FE, 66204 642-5000 32 M 27501 73 FP
DAVIA MD,JAMES E, 10550 QUIVIRA STE 510, 66215 492-6200 37 M 1611 85 CD	GAUGHAN MD,MICHAEL J, PO BOX 10919, 66210 469-8998 49 M 1902 77 R
DAY MD,HUGHES W, 6332 WOODSON DR, 66202 432-3882 15 M 1902 39 OO	GENTRY MD,KALE C, 5105 W 84TH, 66207 642-4242 31 M 1902 60 FP
DEITZ MD,MICHAEL R, 5700 BROADMOOR DR STE 912, 66202 432-0212 32 M 4101 62 OPH	GILBERT MD,ROBERTA M, 4121 W 83RD STE 219, 66208 341-7902 35 F 3506 73 P
DELP MD,MAHLON H, 6131 TERRYDALE RD, 66202 03 M 1902 34 OO	GILLEN MD,BILLY A, 8802 BIRCH LN, 66207 381-0521 29 M 1902 54 ANES
DENISON MD,TERRY R, 5811 OUTLOOK, 66202 432-0625 29 M 1902 56 A	GOLDSTEIN MD,GERALD L, 4601 W 109TH STE 318, 66211 491-5501 47 M 16504 81 P
DERRINGTON MD,KENNETH L, 4601 W 109TH STE 310, 66211 491-6464 44 M 1902 72 FP	GOLLERKERI MD,MOHAN P, 7301 MISSION STE 339, 66208 236-8866 30 M 49516 74 HEM
DOCKHORN MD,ROBERT J, 5300 W 94TH TERR, 66207 381-4674 34 M 1902 61 PDA	GOMEZ MD,FRANCISCO, 4200 SOMERSET #160, 66208 649-7300 15 M 26401 63 P
DOHERTY MD,WILLIAM R, 7600 STATE LINE STE 150, 66208 649-3900 20 M 3006 57 FP	GOOD MD,WENDELL LISLE, 4601 W 109TH STE 212, 66211 491-9183 24 M 1902 48 FP
DRAKE MD,CYNTHIA K, 8901 W 74TH STE 248, 66204 384-4990 57 F 1902 83 OBG	GRASHOFF MD,JOYCE A, 11116 W 114TH, 66210 596-4180 59 F 3005 83 EM
DREILING MD,ROGER J, 8901 W 74TH STE 21, 66204 722-0080 51 M 1902 79 CD	GREENE MD,LAWRENCE S, 10550 QUIVIRA RD STE 510, 66215 492-6200 33 M 3506 81 GE
DUCKETT II MD,THOMAS G, 4601 W 109TH STE 116, 66211 491-4322 41 M 1902 68 OPH	GRIN MD,TRUDI R, 10550 QUIVIRA STE 335, 66215 888-1888 57 F 2846 86 PDO
DURKEE MD,BRUCE W, 10550 QUIVIRA STE 510, 66215 492-6200 52 M 1902 82 ANES	GROSSMAN MD,HARVEY M, 4601 W 109TH STE 122, 66211 491-4045 49 M 1902 77 PD
EMMOTT MD,DAVID F, 8901 W 74TH STE 357, 66204 831-1003 53 M 3901 81 U	GRUNDMEIER MD,ANNETTE M, 9119 W 74TH STE 210, 66204 432-3334 46 F 1611 79 PD
ENDERS MD,WRAY, 9034 COTTONWOOD DR STE 2, 66215 02 M 1902 36 OO	HACKER MD,DAVID C, 6900 W 67TH, 66202 676-2479 50 M 1902 78 ANES
ESRIG D.O., HAROLD L, 8132 SAGAMORE, 66206 381-5033 30 M 2878 62 ANES	HALLERAN III MD,WILLIAM J, PO BOX 10919, 66210 469-8998 53 M 1902 80 DR
ETZENHOUSER III MD,RUSSELL D, 10600 QUIVIRA STE 330, 66215 541-3300 34 M 1902 64 PD	HAMTIL MD,LAWRENCE W, 10550 QUIVIRA RD STE 460, 66215 341-3937 36 M 2803 69 PD
EVANS JR MD,WILLIAM E, 8741 HIGH DRIVE, 66206 362-7363 24 M 1902 59 FP	HARMS MD,ALBERT C, 4200 W 91ST, 66207 13 M 1902 38 OO
EVANS MD,CAROL ANN, 8901 W 74TH STE 228, 66204 362-0000 54 F 2846 82 IM	HARTMAN MD,GERALD V, 6616 EL MONTE, 66208 20 M 1902 45 OO
FORDYCE MD,NORMAN, 8901 W 74TH STE 145, 66204 722-0020 41 M 1902 67 OTO	HARTONG MD,TOBY JOSEPH, 8901 W 74TH STE 328, 66204 384-1441 53 M 1902 83 PD
FRANCISCO MD,CLARENCE L, 3509 W 85TH, 66206 371-6802 09 M 1902 34 OO	HARTONG MD,WILLIAM A, 8901 W 74TH STE 372, 66204 831-9300 44 M 1902 72 IM
FRANKEL MD,SCOTT J, 4601 W 109TH STE 318, 66211 491-5501 53 M 2802 84 A	HATHAWAY MD,PETER, 11055 CEDAR STE 216, 66211 491-3380 31 M 3503 74 IM
GAGE MD,BETSE M, 9119 W 74TH STE 250, 66204 384-5500 55 F 1902 84 PD	HESSER MD,HERBERT H, 7207 EDGEWOOD, 66203 06 M 1902 34 OO

HETTINGER MD, MICHAEL E, 8800 W 75TH STE 310, 66204 677-3113 46 M 4706 81 OPH	KLEMM MD, J MARTIN, 7000 SQUIBB RD #100, 66202 432-9900 53 M 1902 80 P
HILL MD, RODNEY W, 8901 W 74TH STE 208, 66204 362-0300 47 M 1902 75 IM	KODANAZ MD, A AYTEKIN, 5710 REINHARDT DR, 66205 334-2500 28 M 90201 70 ANES
HITCHCOCK MD, C THOMAS, 8901 W 74TH STE 356, 66204 677-2508 47 M 82 GS	KOZIKOWSKI MD, BEN M, 7301 MISSION RD STE 348, 66208 362-8317 30 M 2834 62 ORS
HOBSON MD, MILBURN W, 9119 W 74TH STE 268, 66204 831-2334 30 M 1902 55 OBG	KRISHNAN MD, LEELA, 8800 NALL, 66207 588-3609 43 F 4802 80 RO
HODES MD, HERBERT C, 4840 COLLEGE STE 100, 66211 491-6878 43 M 1902 70 OBG	KRUEGER MD, KURT ALLEN, SMMC PO BOX 2923, 66201 676-2479 48 M 3006 78 ANES
HODGES MD, BRUCE E, 10550 QUIVIRA STE 430, 66215 888-0777 32 M 1902 64 FP	KUBIN MD, DORIS A, 2504 W 71ST, 66208 15 F 1902 43 OO
HOOD MD, ROGER W, 8300 COLLEGE STE 105, 66210 451-9310 48 M 1643 76 ORS	KUEBLER MD, KEVIN M, 8901 W 74TH STE 208, 66204 362-0300 50 M 2101 82 CDTs
HOPKINS MD, LENLY, 7312 ANTIOCH, 66204 722-6121 30 M 3841 65 GS	KURTH MD, ROBERT H, 5555 W 58TH, 66202 432-2080 28 M 3005 59 IM
HOPKINS MD, WILLIAM O, 8575 W 110TH STE 306, 66210 451-1919 33 M 2803 72 ORS	LAPI MD, RUTH M, 2012 STRATFORD RD, 66208 14 F 4107 50 OO
HORSEMAN MD, ROBERT F, 9119 W 74TH STE 306, 66204 432-7419 19 M 1902 44 OBG	LARSON MD, DANUTA OKTAWIEC, 5848 FONTANA DR, 66205 22 F 80303 61 OO
HOUSTON II MD, LAWRENCE MORLEY, 8650 W COLLEGE STE 114, 66210 451-1311 50 M 2803 79 FP	LASH MD, RAY E, 8901 W 74TH STE 21, 66204 722-0080 50 M 1902 76 CD
HSU MD, CECILIA C, 10550 QUIVIRA, 66215 492-6200 43 F 24402 84 PD	LEAHY MD, JAMES D, 8220 TRAVIS STE 115, 66204 342-7184 48 M 3005 PS
INNES MD, ROBERT C, 10226 BRIAR, 66207 25 M 2802 66 OO	LEATHERS MD, HOLLIS K PAT, 9100 W 74TH PO BOX 2923, 66208 676-2340 38 M 3901 77 PATH
JACKSON MD, ROBERT V, 8901 W 74TH STE 10, 66204 362-1660 49 M 2803 80 PD	LEE MD, JAMES G, 5700 METCALF CT, 66202 18 M 1902 44 OO
JANES MD, DONALD R, 10550 QUIVIRA #310, 66215 492-1955 34 M 1902 62 OBG	LEGASPI JR MD, PEDRO L, 9100 W 74TH PO BOX 2923, 66201 676-2479 36 M 74801 71 ANES
JOHNSON MD, JOHN E, 6636 GOODMAN, 66203 281-8815 17 M 4706 57 PATH	LESTER MD, JOHN BUCKLES, 4140 W 71ST STE 108, 66208 432-7276 45 M 1902 71 P
JONES MD, CHARLES E, 9100 W 74TH PO BOX 2923, 66201 676-2214 31 M 1902 61 FP	LEWIN MD, WALTER, 8901 W 74TH STE 269, 66204 362-4040 30 M 1902 56 P
JONES MD, H IVOR, 8901 W 74TH STE 269, 66204 362-4040 24 M 80303 59 P	LEWIS MD, JAMES E, 3700 W 83RD STE 203, 66208 649-0923 37 M 2101 71 P
KADIAN MD, RAJESH S, 10550 QUIVIRA STE 260, 66215 541-0577 50 M 49573 74 IM	LIU MD, JOHNS N, 5500 COLLEGE, 66211 491-9299 51 M 1902 R
KARLIN MD, CHARLES A, 12000 W 110TH STE 500, 66210 469-8998 49 M 1902 76 DR	LULO MD, ANTONIO R, 7600 STATE LINE STE 150, 66208 649-3900 35 M 30801 72 IM
KASHYAP MD, BANSHI PRASAD, 8901 W 74TH STE 257, 66204 236-4500 47 M 49554 78 IM	MACDOUGALL MD, MARGARET L, 6251 ASH, 66202 588-6074 48 F 1902 82 NEP
KATZ MD, FRED S, 8901 W 74TH SUITE 145, 66204 722-0020 50 M 1902 84 OTO	MALLORY MD, JOHN A, 10550 QUIVIRA STE 510, 66215 492-6200 43 M 2803 75 IM
KELLEY MD, GORDON R, 4601 W 109TH SUITE 210, 66211 491-4330 52 M 6002 83 N	MANLEY MD, JOSEPH W, PO BOX 8162, 66208 541-7104 42 M 1902 70 OBG
KETCHUM MD, LYNN D, 12301 W 106TH STE 201, 66215 492-3737 36 M 2101 69 PS	MANTZ MD, FRANK A, 9309 W 103RD, 66212 12 M 4101 61 OO

MARR MD,GARRETT L, 7301 MISSION RD STE 225, 66208
362-6888
44 M 1611 77 GS

MARVIN MD,NORMAN G, 10412 MASTIN, 66212
541-8282
29 M 1902 56 FP

MATHEWS MD,DAVID R, 4610 W 109TH STE 212, 66211
491-9183
53 M 1902 80 FP

MATHEWS MD,ROBERT MAJOR, 7301 MISSION RD STE 225, 66208
362-6888
25 M 1902 54 GS

MAXWELL MD,ROBERT A, 8901 W 74TH STE 10, 66204
362-1660
46 M 1902 75 PD

MCCAUGHEY MD,HUGH W, 11055 CEDAR STE 217, 66211
491-3724
28 M 1902 53 IM

MCEACHEN MD,WILLIAM H, 3700 WEST 83RD STE 102, 66208
649-3335
32 M 1902 60 PD

MCWHERTER MD,LOTTIE B, 5920 NALL STE 308, 66202
362-1464
30 F 1902 58 IM

MIGLIAZZO MD,CARL V, 8800 W 75TH #310, 66204
677-3113
49 M 2803 85 OPH

MILLER MD,FREEMAN LANCE, 10550 QUIVIRA STE 340, 66215
492-1111
48 M 1902 77 PD

MISKEW MD,DON B W, 7301 MISSION STE 348, 66208
362-8317
42 M 6506 80 ORS

MOFFAT MD,ROBERT E, 12000 W 110TH STE 500, 66210
469-8998
42 M 1902 69 DR

MORITZ MD,RICK S, 12316 NIEMAN RD, 66213
371-4343
54 M 1902 81 DR

MORONEY MD,JEAN M, 10550 QUIVIRA STE 510, 66215
492-6200
25 F 4107 68 N

MUEHLBERGER MD,JAMES J, 4601 W 109TH STE 314, 66211
491-3242
34 M 3006 70 PD

MUELLER MD,J KENT, 3700 W 83RD STE 203, 66208
649-0923
35 M 1902 63 P

MUNDEN MD,FRANK A, 5300 W 94TH TERR, 66207
381-4674
38 M 1902 65 A

MURPHY MD,JAY W, 8901 W 74TH STE 21, 66204
722-0080
49 M 3840 74 CD

MURRAY MD,W LEE, 10600 QUIVIRA STE 460, 66215
541-3550
35 M 1902 78 OPH

NASH MD,ROBERT A, 11111 NALL STE 200, 66211
491-6686
31 M 1902 55 P

NAUER MD,PAULA LOU, 7301 MISSION RD STE 342, 66208
384-0745
49 F 1902 78 FP

NAVICKAS MD,LEONARD A, 9119 W 74TH STE 150, 66204
362-5510
53 M 1902 78 FP

NEIBURGER MD,JAMES B, 11111 NALL AVE STE 114, 66211
491-3300
46 M 1642 75 A

NELSON MD,BRYAN C, 9119 W 74TH STE 250, 66204
384-5500
50 M 1902 78 PD

NELSON MD,JOHN B, 10550 QUIVIRA STE 510, 66215
492-6200
48 M 2846 78 PM

NOSTI MD,JUAN C, 8901 W 74TH STE 345, 66204
262-5014
38 M 13204 72 PS

NOTHNAGEL MD,ARNOLD F, 9936 EDELWEISS CIR, 66203
15 M 1902 39 OO

NYE MD,C ERIK, 7301 MISSION RD STE 348, 66208
362-8317
39 M 3520 78 ORS

OLSON MD,THOMAS H, 8901 W 74TH STE 10, 66204
362-1660
54 M 3005 84 PD

OSGOOD MD,GEORGE M, 8020 SANTA FE DR, 66204
381-5200
14 M 1902 44 GP

PATTERSON MD,JOHN R, 5317 CHADWICK RD, 66205
20 M 1902 48 OO

PEARCE MD,EUGENE W J, 9119 W 74TH STE 208, 66204
722-3102
24 M 2802 54 OBG

PEARCE MD,LUNETTA M, 9119 W 74TH STE 208, 66204
362-1525
26 F 3005 52 FP

PENTECOST MD,RICHARD L, 6620 RIGGS, 66202
32 M 1001 65 OO

PETELIN MD,JOSEPH B, 9119 W 74TH STE 355, 66204
432-5420
49 M 1902 81 GPVS

PETERSEN MD,GERALD D, 3700 W 83RD STE 104, 66208
648-3911
30 M 1902 66 IM

PETIT MD,CARL, 10550 QUIVIRA STE 240, 66215
888-1114
33 M 13202 76 GS

PETRIE MD,SAMUEL C, 8331 MAPLE LANE, 66207
649-4333
27 M 1902 60 IM

PFUETZE MD,BRUCE L, 4601 W 109TH STE 318, 66211
491-5501
42 M 1902 69 A

PFUETZE MD,KARL D, 10550 QUIVIRA STE 510, 66215
492-6200
40 M 1902 67 CD

PHILLIPS MD,WARREN G, 3700 W 83RD STE 203, 66208
649-0923
26 M 1902 63 P

PILCHARD MD,WILLIAM A, 8901 W 74TH STE 25, 66204
362-3210
39 M 1602 72 OPH

PIPPIN MD,LYNNE K, 17409 W 66TH TERR, 66217
48 F 35207 72 ANES

PITTS MD,RONALD L, 8901 W 74TH STE 330, 66204
362-2524
35 M 2002 72 D

PORTO JR MD,ANTHONY F, 10550 QUIVIRA STE 360, 66215
894-9125
50 M 3006 85 ENT

POWELL MD,CAROL W, 8216 CHEROKEE CIR, 66206
381-3785
25 F 1902 51 P

POWELL MD,KENNETH A, 8216 CHEROKEE CIR, 66206
381-3785
25 M 1902 53 IM

PRENDES MD,CARLOS A, 6540 W 95TH, 66212
381-5550
50 M 3005 81 FP

PRONKO MD,MICHAEL J, 4121 W 83RD STE 223, 66208
648-7878
34 M 1902 61 P

PROUD MD,G ONEIL, 3721 W 87TH, 66206

13 M 2802 50 OO

QUIGLEY MD,JAMES, 9100 W 74TH PO BOX 2923, 66201
676-2340
50 M 2803 84 PATH

RALSTIN MD,JAMES H, 14708 W 71ST TERR, 66216
299-2069
49 M 1902 78 IM

REED JR MD,WILLIAM O, 8901 W 74TH STE 124, 66204
831-2604
50 M 2803 83 ORS

REIVICH MD,RONALD S, 8900 STATE LN #331, 66206
383-3050
34 M 3806 66 P

RICE MD,BERNARD F, 8901 W 74TH STE 125, 66204
262-9222
31 M 4113 79 END

RICHTER MD,DON G, 9100 W 74TH PO BOX 2923, 66201
676-2479
50 M 1902 79 ANES

RICK JR MD,GREGORY G, 8901 W 74TH STE 372, 66204
831-9300
40 M 1902 67 GE

RIEKHOF MD,PAUL L, 10600 QUIVIRA STE 320, 66215
541-3200
40 M 2803 OBG

RIFFEL MD,LAWRENCE D, 10600 QUIVIRA STE 210, 66215
541-3340
53 M 1902 81 IM

ROBERTSON MD,EDWARD J, 9100 W 74TH PO BOX 2923, 66201
676-2479
46 M 1902 78 ANES

ROBINSON MD,DAVID W, 5500 BELINDER, 66205
588-6136
14 M 4101 40 OO

ROBINSON MD,JOHN D, 9100 W 74TH PO BOX 2923, 66201
676-2464
48 M 1902 75 ANES

ROMITO MD,CYNTHIA L, 10550 QUIVIRA STE 510, 66215
492-6200
47 F 1902 74 A

ROSENBERG MD,STANTON L, 1900 W 75TH STE 200, 66208
362-8080
30 M 1902 55 P

RUBIN MD,HERBERT M, 10550 QUIVIRA STE 340, 66215
492-1111
37 M 2803 72 PD

RYAN MD,MICHAEL E, 4601 W 109TH STE 210, 66211
491-4330
46 M 1902 73 N

RYMER MD,ROBERT A, 8901 W 74TH STE 373, 66204
722-0170
41 M 702 80 OPH

SAFFO MD,KARL S, 8901 W 74TH STE 176, 66204
362-9585
39 M 52801 73 PS

SATHYANARAYANA MD,SARASWATHI, 8901 W 74TH STE 20, 66204
677-2281
45 F 76 OBG

SAWKAR MD,LAXMIDAS A, 8901 W 74TH STE 312, 66204
384-4844
36 M 49523 74 ON

SCHAEFER MD,JOSEPH PETER, 10550 QUIVIRA STE 230, 66215
492-7440
34 M 1902 61 IM

SCHREPFER MD,ROSEMARY, 9119 W 74TH STE 208, 66204
722-3102
22 F 1902 47 OBG

SCHROLL MD,JOHN T, 8901 W 74TH STE 248, 66204
384-4990
51 M 1902 77 OBG

SCLAR MD,WILLIAM C, 10600 QUIVIRA STE 400, 66215
541-3240
46 M 2501 79 GS

SETTLE JR MD,RUSSELL O, 8717 W 110TH STE 350, 66210
451-0430
35 M 1902 61 P

SHAAD MD,DOROTHY J, 2322 W 51ST, 66205
09 F 1902 44 OO

SHAFFER MD,KATHLEEN BRAY, 9119 W 74TH STE 250, 66204
384-5500
54 F 2846 82 PD

SHERIDAN MD,RANDY M, 8901 W 74TH STE 36, 66204
236-6455
53 M 1902 81 OBG

SHOFSTALL MD,WILLIAM H, 6701 WEST 56TH, 66202
11 M 3901 51 OO

SIFERS MD,TIMOTHY M, 8901 W 74TH STE 356, 66204
677-2508
48 M 1902 75 GS

SILLS MD,THOMAS D, 8309 MULLEN RD, 66215
281-8883
49 M 5606 77 EM

SILVER MD,BRADD J, 8901 W 74TH STE 30, 66204
432-2280
50 M 1205 77 IM

SMITH MD,DALE C, 5520 COLLEGE, 66211
491-3737
20 M 1902 45 OPH

SMITH MD,DONALD J, 8600 W 95TH, 66212
642-4515
18 M 1902 49 FP

SMITH MD,MONT A, 8901 W 74TH STE 208, 66204
362-0300
48 M 3901 86 TS

SMITH MD,WILLIAM P, 12000 W 110TH STE 500, 66210
469-8998
51 M 1902 79 R

SNODELL MD,FIRMIN E, 5555 W 58TH, 66202
432-2080
31 M 1902 62 IM

SNOW JR MD,ARTHUR D, 9119 W 74TH STE 150, 66204
362-5510
45 M 1902 76 FP

STEVENSON MD,E KENT, 4121 W 83RD STE 150, 66208
649-5566
45 M 2802 74 CHP

STRIEBINGER MD,CHARLES M, 9119 W 74TH #303, 66204
432-1100
45 M 1606 77 NS

STUBER MD,JACK LAWRENCE, 12000 W 110TH STE 500, 66210
469-8998
40 M 1902 67 DR

STUCKEY MD,CHARLES E, 10600 QUIVIRA STE 350, 66215
541-3377
41 M 3005 80 GS

SUGAR MD,ROBERT L, 8901 W 74TH STE 248, 66204
384-4990
40 M 3508 72 OBG

SULLIVAN JR MD,HENRY B, 5817 NIEMAN RD, 66203
631-6160
24 M 1902 52 FP

SULLIVAN MD,TOM G, 10600 QUIVIRA STE 320, 66215
541-3200
44 M 1902 75 OBG

SUTTON JR MD,RICHARD L, 3203 W 83RD, 66206
08 M 2501 38 OO

TACKETT MD,RUSSELL E, 8901 W 74TH STE 353, 66204
677-2460
54 M 2803 U

TAYLOR MD,THOMAS L, 8901 W 74TH STE 34, 66204
362-9444
40 M 1902 67 GS

TENNY MD,ROBERT T, 9119 W 74TH STE 303, 66204
432-1100
51 M 1902 81 NS

THOMAS MD,MARTY H, 10600 QUIVIRA STE 320, 66215
541-3200
51 F 1902 84 OBG

THOMSEN MD,GARY, 9119 W 74TH STE 150, 66204
362-5510
51 M 3005 77 FP

TOALSON MD,WILLIAM B, 8901 W 74TH STE 21, 66204
722-0080
37 M 1902 64 CD

TRETBAR MD,LAWRENCE L, 8901 W 74TH STE 300, 66204
677-1776
33 M 1902 67 GS

TUCKER MD,SHERIDAN G, 4121 W 83RD STE 150, 66208
649-5566
50 M 1902 77 CHP

TURNER MD,MARC A, 10550 QUIVIRA RD, 66209
541-5379
53 M 1902 79 ANES

VALK MD,WILLIAM L, 5401 W 81ST, 66208
588-6146
09 M 2501 46 OO

VANNAMAN MD,DONALD D, 10600 QUIVIRA STE 330, 66215
541-3300
43 M 1902 72 PD

WALKER MD,JACK D, 10107 HARDY DR, 66212
22 M 1902 53 OO

WALKER MD,WILLIAM L, 10550 QUIVIRA STE 510, 66215
492-6200
44 M 1902 70 DR

WANG MD,SIDNEY W, 10550 QUIVIRA STE 130, 66215
492-1500
32 M 38503 70 FP

WARNER MD,RICHARD B, 10550 QUIVIRA STE 480, 66215
541-9328
45 M 1902 85 P

WAXMAN MD,DAVID, 12516 W 85TH TERR, 66215
588-1227
18 M 3515 70 IM

WEBB MD,JAMES R, 5949 NIEMAN RD, 66203
631-0900
34 M 1902 62 FP

WHITE MD,JOHN P, 8347 VALLEY VIEW, 66212
17 M 1902 42 OO

WHITEHEAD MD,RICHARD E, 7301 MISSION RD SUITE 348, 66208
362-8317
31 M 2501 65 ORS

WHITLEY MD,DOUGLAS M, 4601 W 109TH SUITE 202, 66211
491-3376
34 M 1902 61 D

WIEN MD,STEVEN M, 12456 W 62ND TERR, 66216
268-4454
50 M 1902 84 FP

WIGGINTON D.O., GERALD D, 9119 W 74TH STE 250, 66204
384-5500
44 M 2878 73 PD

WILEY MD,JOHN H, 9119 W 74TH STE 268, 66204
831-2334
37 M 4113 70 OBG

WILLIAMS MD,THOMAS A, 10550 QUIVIRA #130, 66215
894-6317
36 M 1902 63 FP

WILSON MD,ROBERT B, 10925 W 98TH, 66214
10 M 1902 40 OO

WILSON MD,SLOAN J, 5618 W 62ND, 66202
10 M 1902 36 OO

WOOD MD,FRED M, 8901 W 74TH SUITE 124, 66204
831-2604
38 M 4706 80 ORS

WURSTER MD,GEORGE R, 3700 W 83RD STE 203, 66208
649-0923
35 M 1902 62 P

YE MD,RICHARD C, 7301 MISSION RD STE 317, 66208
362-7505
20 M 24222 55 PS

YEOMANS MD,RONALD N, 4401 W 109TH, 66211
345-1400
40 M 1902 68 OBG

YOHE MD,RUTH M, 8600 W 95TH, 66212
383-3377
26 F 4107 59 PDA

YOUNG MD,JOHN W, 8220 TRAVIS STE 115, 66204
383-1550
37 M 4706 72 PS

ZACK MD,ASHLEY S, 4601 WEST 109TH STE 122, 66211
491-4045
46 M 2803 74 PD

ZAMIEROWSKI MD,DAVID S, 8800 W 75TH STE 340, 66204
831-4113
42 M 2307 78 PS

SMITH CENTER — 913 (Central Kansas Medical Society)

SHEPPARD MD,ROBERT G, 400 W COURT, 66967
282-6654
21 M 1902 45 OO

STEINKRUGER MD,VERLYN WILLIAM, PO BOX 290, 66967
282-6661
28 M 3005 54 FP

SOUTH HAVEN — 316

UBELAKER MD,ERNEST J, , 67140
892-2261
11 M 1902 38 FP

ST. FRANCIS — 913 (Northwest Kansas Medical Society)

CRAM MD,ERNEST R, PO BOX 625, 67756
332-2126
24 M 1902 52 FP

STEPHENSON MD,LUCILLE C, BOX 824, 67756
06 F 1902 32 FP

ST. MARYS — 913 (Pottawatomie County Medical Society)

BROWN MD,FRED E, 602 W PALMER, 66536
437-2256
26 M 1902 55 FP

ENGELKEN MD,SUSAN F, 607 WALNUT, 66536
437-2256
49 F 3401 84 GP

KOSA MD,ANNAMARIA, PO BOX 154, 66536
00 F GS

STAFFORD — 316
(Ninnescah Medical Society)

BROWN MD,C EVERETT, PO BOX E, 67578
10 M 1902 47 OO
FARMER III D.O. ,F J, PO BOX 309, 67578
234-6826
52 M 2878 80 FP
QUIJANO JR MD, RAMON S, 412 E GRAN, 67578
234-5236
45 M 74811 83 GP

STERLING — 316
(Rice County Medical Society)

DYSART MD,JACK C, 224 N FOURTH, 67579
12 M 3901 41 OO
SIMPSON MD,TOM C, 239 N BROADWAY, 67579
278-2123
47 M 1902 74 FP

STOCKTON — 913
(Central Kansas Medical Society)

MAUCK MD,HAROLD C, 623 SOUTH 2ND, 67669
425-6280
20 M 1902 54 FP
VOTAPKA MD,WILLIAM L, 623 S SECOND, 67669
425-6280
24 M 1902 53 FP

SUBLETTE — 316
(Southwest Kansas Medical Society)

THIEMANN D.O. ,A H, 301 DERBY, 67877
675-2241
12 M 1875 57 FP

SYRACUSE — 316
(Southwest Kansas Medical Society)

PARKS MD,DOUGLAS S, 700 HUSER, 67878
384-5731
56 M 1902 84 FP
PETERSON MD,CECIL E, PROFESSIONAL ASSN BOX 1045, 67878
384-5731
14 M 1902 39 FP
SHARMA MD,S A, PO BOX 1087, 67878
384-7735
44 F 49530 84 PD

TONGANOXIE — 913
(Leavenworth County Medical Society)

STEVENS MD,PHILIP L, BOX 319, 66086
845-2090
27 M 1902 54 FP

TOPEKA — 913
(Shawnee County Medical Society)

ABBO MD,GORDON E, 3107 W 21ST, 66604
296-5391
48 M 1803 81 P
ALLEN MD,JAMES E, 600 SE MADISON, 66607
354-5294
46 M 1902 73 IM
ARJUNAN MD, K N, 901 GARFIELD, 66606
357-6171
44 M 49568 83 NS
ARUNAKUL MD,PUNYA, 1710 W TENTH, 66604
234-2624
44 M 89104 80 OTO
ASHLEY JR MD,B JOHN, 1616 WEST 8TH ST, 66606
233-2280
31 M 1902 56 OPH
ASHLEY MD,BYRON J, 3222 PLASS, 66611
98 M 1902 24 OPH
ATLURU MD,NARAYANA RAO, 5207 W 11TH TERR, 66604
232-8761
47 M 49550 76 CD
ATWOOD MD,MICHAEL D., 631 HORNE STE 340, 66606
232-9394
56 M 1902 84 FP
AVERILL MD,STUART C, MENNINGER FD BOX 829, 66601
273-7500
24 M 502 58 P
BAEHR MD,RALPH H, 7505 ROBINHOOD CT, 66614
35 M 1606 65 OO
BAIR MD,GLENN O, 2300 SW 29TH #123, 66611
267-3025
31 M 2401 59 IM
BAKER MD,PHILLIP L, 909 MULVANE, 66606
357-0301
37 M 3005 63 ORS
BAKER MD,RAY D, 1615 W EIGHTH PO BOX 118, 66601
233-8961
30 M 4812 67 GPM
BARABAN MD,MARC R, 823 MULVANE STE 200, 66606
357-5325
50 M 2846 80 PS
BARNETT MD,ROBERT E, 823 MULVANE STE 280, 66606
235-0202
00 M 2802 84 OBG
BASSETT MD,PAUL M, PO BOX 326, 66601
354-6100
52 M 1902 80 EM
BEACH MD,RICHARD R, HMO KANSAS BOX 110, 66601
295-4832
23 M 2802 54 OO
BEALE MD,DAVID A, MENNINGER FD BOX 829, 66601
273-7500
31 M 5404 64 P
BECK MD,JOSEPH D, 2760 SW BURLINGAME RD, 66611
18 M 3005 47 OO
BEDFORD MD,D R, PO BOX 1772, 66615
09 M 4802 46 OO
BEELMAN MD,FLOYD C, 1286 LAKESIDE DR, 66604
02 M 3840 36 FP
BELLER MD,WILLIS L, 63 PEPPERTREE LN, 66611
14 M 1902 41 OO
BLAKE MD,HENRY S, 1933 WESTWOOD DR, 66604
11 M 3520 42 OO

BONEBRAKE MD,C RICHARD, 634 MULVANE STE 104, 66606
233-1979
48 M 1606 79 OBG

BOREL MD,DAVID, 1700 W 7TH PATH DEPT, 66606
295-8473
45 M 1902 72 PATH

BOWEN JR MD,HARRY J, 1900 SW PEMBROOK LN, 66604

11 M 1902 37 OO

BOWEN MD,CLOVIS W, 2200 WEST 10TH, 66604

234-8601
12 M 1902 37 FP

BOWEN MD,JUDITH M, MENNINGER FD BOX 829, 66601

273-7500
55 F 4720 84 P

BOYD MD,SPENCER H, 1815 WEST 2ND, 66606

11 M 1902 35 OBG

BRAHMAN MD,HERBERT D, 1700 SEVENTH, 66606

295-8471
43 M 512 79 PATH

BRAUN MD,ROBERT W, 901 GARFIELD, 66606

354-9591
44 M 2803 76 IM

BRIDWELL MD,RUSSELL E, 1710 W TENTH, 66604

234-2624
26 M 1902 51 ENT

BRUNER JR MD,KENNETH W, 4505 W 64TH, 66208

262-3286
44 M 2401 74 PATH

CACHIA MD,RICHARD M, 1700 W 7TH PATH DEPT, 66606

295-8472
51 M 62701 78 PATH

CASHMAN JR MD,MAURICE R, 901 GARFIELD, 66606

354-9591
35 M 1902 66 HEM

CHAMBERLIN JR MD,CECIL R, BOX 829, 66601

273-7500
30 M 3901 63 CHP

CHEN MD,CHU-CHI, CTRL UROLOGY 1710 W 10TH #200, 66604

354-4465
47 M 24405 81 U

CHEN MD,TAK-MING, 1001 HORNE STE 308, 66604

234-3451
41 M 24402 76 ANES

CHERRY JR MD,ARTHUR C, 1125 SW GAGE, 66604

273-9813
27 M 3806 58 PD

CLARK MD,CRAIG N, 300 SE NORWOOD, 66607

29 M 1902 58 OO

COCHRAN MD,PAUL W, MENNINGER FD BOX 829, 66601

273-7500
33 M 4802 76 IM

COHEN MD,LOUIS, 823 MULVANE, 66606

233-7175
14 M 1902 41 IM

COKELEY MD,JOHN M, 2200 GAGE, 66622

272-3111
30 M 5104 66 P

COKER MD,W LAURENCE, 631 HORNE #340, 66606

232-9394
53 M 1902 81 FP

COLLINS MD,DEAN T, MENNINGER FD BOX 829, 66601

273-7500
28 M 1902 55 P

COLLINS MD,EDWARD JOSEPH, 900 WASHBURN, 66606

233-3242
45 M 1611 77 OPH

CONROY MD,ROBERT W, MENNINGER FD BOX 829, 66601

273-7500
38 M 2604 71 P

COOK EXEC DIR ,BYRON, SHAWNEE COUNTY MED SOCIET, 66606

234-5668
00 M

COOLEY MD,DENNIS M, 1125 SW GAGE B, 66604
273-9813
51 M 1902 79 PD

COPPLE JR MD,HAL E, 904 SW MULVANE, 66606

232-8224
46 M 3005 84 PNP

COTTON MD,ROBERT T, 7520 OXFORDSHIRE RD, 66614

19 M 1902 45 OO

CRARY MD,JOHN E, 1001 GARFIELD STE 201, 66604

233-4202
18 M 1902 43 IM

CRIDER MD,SUSAN L, 2115 W 10TH, 66604

232-2244
52 F 1902 86 PATH

CROUCH MD,STEVEN W, 904 MULVANE, 66606

232-8224
51 M 1902 77 PD

CROUCH MD,WILLIAM H, 904 MULVANE, 66606

232-8224
20 M 2802 51 PD

DAUGHETY MD,TED W, 901 GARFIELD, 66606

345-9591
00 M IM

DAVIS MD,CHESTER R, 631 HORNE STE 130, 66606

232-6020
50 M 1902 76 FP

DELGADO MD,SERGIO, 634 MULVANE STE 200, 66606

357-0352
37 M 2501 74 ORS

DESOIGNIE MD,RAFAEL R, 2537 BURNETT RD, 66614

19 M 27501 78 OO

DUNAGIN MD,JACK A, 925 WESTERN, 66606

233-7138
20 M 1902 44 P

DUNIVEN MD,PHILIP L, 1001 HORNE STE 310, 66604

234-3451
52 M 4812 81 R

DURST JR MD,ROBERT D, 1706 SW TENTH, 66604

357-5166
42 M 2803 72 D

EATON MD,EDWARD L, 925 WESTERN, 66606

233-7138
40 M 401 73 P

ELDER MD,D MIKEL, 1001 HORNE STE 310, 66604

234-3451
41 M 1902 73 DR

FAROOKI MD,ZIA O, 901 GARFIELD, 66606

233-1710
43 M 70401 PDC

FEAGAN MD,JERRY, 901 GARFIELD, 66606

354-9591
39 M 1902 64 GE

FEIFAREK MD,MICHAEL J, 900 WASHBURN, 66606

233-1800
50 M 5605 OPH

FERNANDEZ MD,LUIS A, 2707 WEST 13TH, 66604

233-8961
14 M 27501 68 PD

FERNANDEZ MD,MIGUEL A, 808 SW WASHBURN #18, 66606

232-2885
43 M 27502 83 GS

FIELD MD,RICHARD A, 1001 HORNE STE 308, 66604

235-3451
29 M 1902 55 ANES

FILLMAN MD,ELDON M, 1001 GARFIELD STE 301, 66604

233-4256
20 M 1611 49 U

FORD MD,FRED L, 1264 LAKESIDE DR, 66604

11 M 2501 39 OO

FOSTER MD,D BERNARD, 3111 JEWELL, 66611	HARVEY MD,R CLAY, 1001 HORNE #310, 66604
14 M 2501 47 OO	234-3451
FRANKLIN JR MD,BENJAMIN A, 1001 HORNE #310, 66604	52 M 1902 79 R
234-3451	HEBBAR MD,SATYA N, 634 MULVANE STE 100, 66606
45 M 1902 77 R	233-9643
GANDHI MD,SHANTIKUMAR K, 634 SW MULVANE STE 203, 66606	39 M 49509 74 CD
233-1690	HEEB MD,CAMILLE S., 1125 SW GAGE, 66604
40 M 49501 78 TS	273-9813
GANZARAIN MD,RAMON C, MENNINGER FD BOX 829, 66601	44 F 1902 83 PD
273-7500	HERRERA MD,JORGE J, 2825 CALIFORNIA, 66605
23 M 23101 73 P	267-5370
GAY MD,JOHN D, 1001 HORNE STE 310, 66604	27 M 64901 74 IM
234-3451	HICKMAN MD,JAMES STEPHEN, 634 MULVANE STE 103, 66606
42 M 4802 74 DR	233-8508
GENDEL MD,JOSEPH E, PO BOX 4127, 66604	53 M 2803 82 PD
235-9914	HIEBERT MD,JOHN B, 901 GARFIELD, 66606
12 M 4804 52 ORS	354-9591
GIERBOLINI MD,JOSE I, 1500 SW TENTH, 66606	40 M 1902 72 CD
354-6850	HILL MD,ROBERT N, 901 GARFIELD, 66606
52 M 4201 85 NEO	354-9591
GIESSEL MD,MICHAEL D, 901 GARFIELD, 66606	14 M 1902 68 IM
354-9591	HILST MD,WILBUR D, 1271 WOODHULL, 66604
48 M 1902 74 D	273-5870
GIMPLE MD,KENNETH, 631 HORNE STE 200, 66606	31 M 3005 61 GS
233-7491	HIRSCHBERG MD,J COTTER, MENNINGER FD BOX 829, 66601
45 M 1902 78 ORS	273-7500
GLEASON MD,JIMMIE A, 800 LINCOLN, 66606	15 M 1602 52 CHP
233-5101	HISZCZYNSKYJ MD,ROMAN, 1500 W TENTH, 66606
33 M 1902 60 OBG	354-6870
GOERING MD,EMIL L, 700 HARRISON, 66636	35 M 1803 70 PATH
295-3175	HOBBS MD,DONALD D, 631 HORNE STE 200, 66606
27 M 1902 57 IM	233-7491
GRAY MD,DAVID E, 3633 SW DRURY LN, 66604	28 M 2401 63 ORS
16 M 1606 42 OO	HOHERZ MD,DAVID G, 823 MULVANE, 66606
GRAYIB MD,ANTOINE S, 1625 OAKLEY, 66604	235-1170
18 M 60501 58 OO	45 M 1803 75 TS
GREENBERG MD,MARK, 1001 HORNE STE 310, 66604	HOLMES MD,ROBERT W, 901 GARFIELD, 66606
234-3451	354-9591
46 M 1611 76 R	52 M 1902 80 IM
GREENE MD,HORACE T, 156 SW FAIRLAWN RD, 66606	HOSTETTER MD,MARCIA M, 634 MULVANE #104, 66606
15 M 401 47 OO	233-1979
GREENE MD,RUSSELL E, 1001 HORNE #310, 66604	46 F 1902 74 OBG
295-8008	HOYT MD,ARTHUR W, 2521 NW 35TH, 66618
53 M 515 83 RT	234-5663
GREER MD,RICHARD H, 1207 W 29TH A-7, 66611	14 M 2501 55 P
09 M 1902 39 OO	HSU MD,CHENG H, 1516 W SIXTH, 66606
GUILLAN MD,RAMON A, 2200 GAGE, 66622	232-1005
267-1467	41 M 38502 74 U
30 M PATH	HSU MD,SHIN-FU, 1001 GARFIELD #203, 66604
GUTOVITZ MD,ALLEN LOUIS, 634 MULVANE STE 100, 66606	232-0362
233-9643	43 M 24402 OTO
46 M 1611 79 CD	HUANG MD,JONSON, 901 GARFIELD, 66606
HACKER MD,ELAINE MARY, 3026 QUAIL CREEK, 66614	357-6171
296-3981	52 M 2701 81 N
25 F 2604 78 OBG	HUSTON MD,JOSEPH W, 634 MULVANE, 66606
HALLEY MD,M MARTIN, 901 GARFIELD, 66606	357-0352
233-1710	35 M 1902 63 ORS
27 M 2401 59 TS	HUTTON MD,FREDERICK A, 1001 GARFIELD STE 102, 66604
HARRIS MD,HUBERT L, 1001 HORNE STE 210, 66604	234-0553
233-3151	29 M 6701 66 PS
12 M 1803 49 D	HYLAND MD,JOSEPH M, MENNINGER FD BOX 829, 66601
HARRIS MD,PATRICIA A, 1617 W 26TH, 66611	273-7500
29 F 1902 54 OO	45 M 53902 74 P
HARRISON MD,HALL E, 901 GARFIELD, 66606	ILIFF MD,R DOUGLAS, 1119 GAGE, 66604
354-9591	271-6161
39 M 2802 72 IM	49 M 1902 80 FP
	ILORETA MD,ALFREDO T, 1516 W SIXTH, 66606
	232-1005
	47 M 74801 80 U
	ISAACSON MD,RICHARD N, 1001 GARFIELD STE 301, 66604
	233-4256
	48 M 2501 80 U

JACKSON JR MD,DONALD H, 634 MULVANE #100, 66606
233-9643
40 M 3515 84 CD

JACOBY II MD,ROBERT E, 631 HORNE STE 634, 66606
232-9394
46 M 2307 75 FP

JANSSEN MD,ERWIN T, MENNINGER FD BOX 829, 66601
273-7500
36 M 1803 70 P

JENSEN MD,ROBERT D, 1500 W TENTH, 66606
354-6031
53 M 3005 83 PATH

JETTE MD,N TIMOTHY, 4150 W 6TH #110, 66606
46 M 801 86 ANES

JOSEPH MD,BRIAN W, 925 WESTERN, 66606
233-7138
38 M 35205 74 CHP

JOSS MD,CHARLES S, 1400 STRATFORD, 66604
14 M 1606 40 OO

JOYCE MD,G BERNARD, 4929 WEST HILLS DR, 66606
17 M 1902 44 OO

KATZ MD,JEROME B, BOX 829, 66601
273-7500
22 M 2101 52 P

KAVEL MD,KARL K, 1123 SW GAGE, 66604
273-9999
36 M 3605 72 PDA

KEARNS MD,NORBERT W, MENNINGER FD BOX 829, 66601
273-7500
43 M 1002 72 P

KELLY MD,DAN A, 904 MULVANE, 66606
232-8224
39 M 2803 69 PD

KEYS JR MD,ROBERT C, 1001 HORNE STE 308, 66604
235-3451
36 M 1902 64 ANES

KIM MD,YONG W, 631 HORNE STE 110, 66606
232-6964
28 M 58302 61 IM

KINDLING MD,PAUL H, 901 GARFIELD, 66606
233-1710
30 M 3545 68 TS

KIRKEGAARD MD,RODGER S, 835 WESTERN, 66606
233-6493
30 M 1803 64 OPH

KLEINHOLZ JR MD,EMIL JOHN, 634 MULVANE #201, 66606
232-1227
39 M 3503 79 IM

KLEMMER MD,HERBERT, 904 MULVANE MED PARK CL, 66606
233-5033
11 M 4102 56 P

KOHAKE MD,GEORGE A, 600 MADISON, 66607
354-4400
54 M 1902 86 EM

KOONTZ MD,JUDITH A, BOX 829, 66601
233-5033
49 F 1902 81 CHP

KOOSER MD,JUDITH A, 1700 7TH, 66606
295-8008
47 F 1601 85 TR

KOVARIK MD,ERNEST D, 900 WASHBURN, 66606
233-1800
36 M 3005 71 OPH

KROLL MD,HARRY G, 2912 CEDAR COVE CT, 66614
24 M 1602 57 OO

LACCHEO MD,MICHAEL L, 1119 GAGE, 66604
271-6000
51 M 3840 82 FP

LAI MD,MAX G, 1710 W 10TH, 66604
354-4465
45 M 24405 81 U

LAUNEY MD,WALTON S, 1001 HORNE #310, 66604
234-3451
39 M 4804 81 R

LAWSON MD,DWIGHT, 1203 SW 29TH STONE HOUSE #2, 66611
06 M 2802 44 OO

LEE MD,SONG DOW, 1001 HORNE STE 308, 66604
235-3451
43 M 38505 74 ANES

LEE MD,SONG PING, 823 MULVANE STE 250, 66606
233-6001
34 M 38502 74 OTO

LEIFER MD,WILLIAM N, 1500 W TENTH, 66606
354-6870
47 M 1902 78 PATH

LENTZ MD,WILLIAM R, 634 MULVANE #400, 66606
295-5400
24 M 1902 53 FP

LEPSE MD,PETER S, 909 MULVANE, 66606
357-0301
57 M 1803 ORS

LESSENDEN JR MD,C M, 5635 NW BRICKYARD RD, 66618
272-3111
18 M 1902 43 D

LEVY MD,EDWIN Z, 4125 SW GAGE L-6 PO BOX 4311, 66604
273-5610
29 M 1606 59 P

LIESMANN MD,GEORGE E, 823 MULVANE, 66606
235-1170
49 M 1902 81 GPVS

LIESMANN MD,JEAN ELIZABETH, 901 GARFIELD, 66606
354-9591
49 F 1902 77 IM

LOGAN MD,WILLIAM S, PO BOX 829, 66601
273-7500
49 M 4812 84 P

LUI MD,NASON, 1516 W SIXTH, 66606
233-1747
48 M 1606 83 GPVS

LYNCH MD,JOHN A, 909 MULVANE, 66606
357-0301
30 M 2834 64 ORS

MARSHALL MD,B M, 1826 SW 34TH, 66611
08 M 2802 34 U

MARTIN MD,WILLIAM O, 1001 HORNE STE 308, 66604
235-3451
19 M 1902 44 ANES

MAU MD,WALTER, 3901 SW CHELMSFORD RD, 66610
16 M 1611 49 OO

MCCARTER MD,DUANE K, 2101 W 10TH, 66604
233-8979
26 M 1902 65 IM

MCCOMAS JR MD,MARMADUKE D, 3020 BRUSH CREEK CR, 66614
16 M 1902 43 U

MCCOY MD,MICHAEL T, 823 MULVANE, 66606
233-0117
49 M 1902 80 ORS

MCELROY MD,ROBERT T, 823 MULVANE STE 220, 66606
232-0444
35 M 1902 62 GS

MCELROY MD,WILBUR J, C/O 1001 HORNE #221, 66604
233-2280
35 M 1902 62 OPH

MCKINNEY D.O., SHARON L, 5201 BELLE TERR, 66604
272-3111
41 F 2878 RM

MEGIBOW MD,ALAN D, 925 WESTERN, 66606 233-7138 37 M 3503 74 CHP	PATEL MD,VINOD, 655 WESTCHESTER RD, 66601 354-5166 47 M 49531 74 N
MEIDINGER MD,RICHARD, 1001 HORNE STE 310, 66604 295-8011 39 M 1902 66 DR	PATRICK MD,FRED EDWARD, 904 MULVANE, 66606 232-8224 45 M 1902 72 PD
MENNINGER MD,KARL A, BOX 829, 66601 273-7500 93 M 2401 17 P	PAYNE MD,ROBERT R, 631 HORNE STE 200, 66606 233-7491 29 M 1902 55 ORS
MENNINGER MD,ROBERT G, MENNINGER FD BOX 829, 66601 232-7214 22 M 3545 53 P	PERDUE II MD,W LANG, 631 HORNE STE 400, 66606 354-9504 49 M 1902 81 GS
MENNINGER MD,ROY W, BOX 829, 66601 273-7500 26 M 3520 62 P	PETERSON MD,DEAN L, 2825 SW PLASS, 66611 24 M 1902 54 OO
MENNINGER MD,W WALTER, MENNINGER FD BOX 829, 66601 273-7500 31 M 3520 59 P	PETERSON MD,ROBERT L, PO BOX 326, 66601 354-6108 36 M 1902 63 EM
MEYER MD,O WARREN, 634 MULVANE #100, 66606 233-9643 49 M 1902 80 CD	PETERSON MD,VERNON J, 1001 HORNE STE 310, 66604 234-3451 42 M 512 73 R
MHATRE MD,VIJAY R, 620 SE MADISON, 66607 232-4566 49 M 49528 84 IM	PETRIK MD,EDWIN L, EBA MED CTR 620 SE MADISON, 66607 232-4566 35 M 1902 65 IM
MILLS JR MD,PHILIP E, 901 GARFIELD, 66606 357-6171 36 M 1902 65 N	PETTERSON MD,DENNIS CRAIG, 1001 HORNE STE 310, 66604 234-3451 49 M 1902 76 R
MODLIN MD,HERBERT C, MENNINGER FD BOX 829, 66601 273-7500 13 M 3005 50 P	PFUETZE MD,ROBERT E, 1001 HORNE STE 209, 66604 232-3332 09 M 1902 35 OBG
MODLIN MD,HERBERT C, 1500 W TENTH, 66606 354-6870 13 M 3005 50 P	PIERCE MD,CHARLES F, 4108 SW EMLAND DR #3, 66606 235-6282 24 M 4101 55 OBG
MORRIS MD,MERLE D, 2800 MAC VICAR, 66611 21 M 1902 45 OO	PIERCE MD,DONALD R, 1001 HORNE STE 307, 66604 235-2226 23 M 5101 50 FP
MORRISON MD,MICHAEL R, 800 LINCOLN, 66606 233-5101 50 M 1902 78 OBG	POLLY MD,RICHARD E, 909 MULVANE, 66606 357-0301 42 M 1803 75 ORS
MUELLER MD,ARNOLD V, 901 GARFIELD, 66606 354-9591 31 M 3005 58 IM	PORTER MD,ROBERT D, 901 GARFIELD, 66606 354-9591 41 M 2802 73 IM
MYERS MD,JO ANN, MENNINGER FD BOX 829, 66601 273-7500 28 F 1902 53 P	POWELL II MD,BENSON M, 631 HORNE STE 400, 66606 354-9504 26 M 1606 55 TS
NABOURS MD,RICHARD D, 4228 W 29TH ST TERR, 66614 272-7190 27 M 1902 54 FP	POWELL MD,WILLIAM R, 833 GARFIELD, 66606 233-8941 30 M 1902 54 GS
NATHAN MD,WILLIAM A, MED PARK CL 904 MULVANE, 66606 233-5033 48 M 3503 CHP	PRESTON MD,RALPH R, 1710 WEST 10TH, 66604 234-2624 19 M 1902 44 OPH
NICE MD,G WILLIAM, 1001 HORNE STE 112, 66604 235-8090 22 M 1902 46 IM	PRICE JR MD,LAURANCE W, 1500 WEST 10TH, 66606 354-6874 33 M 1902 60 PATH
NOVOTNY MD,PETER C, MENNINGER FD BOX 829, 66601 273-7500 30 M 15407 63 P	PROKOP MD,BRADFORD S, 920 SW WASHBURN, 66606 233-3900 32 M 1606 61 OPH
O'NEIL MD,ROBERT H, 901 GARFIELD, 66606 354-9591 20 M 1902 45 IM	PYLE MD,LUCIEN R, 3139 CANTERBURY LN, 66604 01 M 1601 30 OBG
OBOURN MD,ROBERT L, 1150 OAKLEY, 66604 273-7500 19 M 2802 51 OO	RAINBOW-EARHART MD,KATHRYN A, 2916 KENTUCKY, 66605 21 F 4707 63 OO
OWEN III MD,JAMES W, 1001 HORNE STE 310, 66604 234-3451 54 M 2802 83 DR	RAJU MD,A S PADMA, 1710 W 10TH STE 208, 66604 234-3211 39 M 49509 81 TS
PARMAN MD,ROBERT D, 904 MULVANE, 66606 232-8224 27 M 1902 54 PD	RAMSAY MD,GRACE A, 800 LINCOLN, 66606 233-5105 48 F 1902 81 OBG
PASCUA MD,PERCIVAL G, BOX 829, 66601 273-7500 39 M 74808 80 IM	RAMSEY MD,BARTLETT W, 904 MULVANE, 66606 232-8224 25 M 1902 50 PD

RANDALL MD,GORDON R, 1001 HORNE STE 310, 66604 234-3451 50 M 4706 83 R	SCAMMAN MD,W WIKE, 2115 W 10TH, 66604 232-2322 32 M 4705 64 PATH
RANDELL MD,EDGAR C, 800 LINCOLN, 66606 233-5101 41 M 3005 71 OBG	SCHLOESSER MD,HARVEY L, 918 MERCHANTS NATL BK, 66612 235-3184 21 M 3901 55 P
RANSOM MD,JAMES H, 1123 SW GAGE, 66604 273-9999 36 M 1803 67 A	SCHLOESSER MD,PATRICIA T, 1914 WARNER CT, 66604 862-9360 24 F 3901 53 PD
REINKING MD,VICTOR E, 631 HORNE STE 110, 66606 233-5084 26 M 1902 52 IM	SCHMIDT MD,MICHAEL J, 631 HORNE STE 200, 66606 233-7491 54 M 1902 84 ORS
REYMOND MD,RALPH D, S-F CAP REG RADIOTHER CTR, 66606 295-8008 37 M 2301 72 R	SCHRAM MD,PETER CHARLES, PO BOX 829, 66601 273-7500 39 M 2507 76 P
RICCI MD,ROBERT LAWLER, 901 GARFIELD, 66606 354-9591 50 M 1902 76 IM	SEHDEV MD,JOAN, 1001 HORNE STE 303, 66604 233-3553 40 F 6101 74 FP
RICH MD,JOSEPH E, WOMENS HLTH CTR 2200 SW 6TH, 66606 233-2700 47 M 40921 81 OBG	SETTLE SR MD,RUSSELL O, 1208 SW 29TH TER APT S25, 66611 04 M 1902 29 OO
RICHARDSON MD,J M, 634 SW MULVANE #404, 66606 232-7762 47 M 1611 77 IM	SHAW MD,JOSEPH L, 1001 HORNE STE 204, 66604 235-6221 34 M 511 72 ORS
RICKETTS-KINGFISHER MD,DAVID J, 1001 GARFIELD STE 101, 66611 354-4740 47 M 1902 84 EM	SHEAFOR MD,DOUGLAS, 925 WESTERN, 66606 233-7138 34 M 1902 61 P
ROBERTS MD,WARREN E, PO BOX 4047, 66604 272-5797 25 M 1902 57 FP	SHELTON MD,STEPHEN E, 925 WESTERN, 66606 233-7138 35 M 702 67 P
ROBINSON MD,DAVID B, 800 LINCOLN, 66606 233-5101 47 M 1902 74 OBG	SHERWOOD JR MD,CLARENCE E, 631 HORNE STE 400, 66606 354-9504 22 M 702 62 GS
RODRIGUEZ MD,ALBERTO, 2700 W 6TH, 66606 296-4347 25 M 27501 76 GP	SHEU MD,W ERIC, 1001 HORNE STE 308, 66604 235-3451 43 M 38505 82 ANES
ROEDER MD,ROBERT E, 901 GARFIELD, 66606 354-9591 40 M 1902 68 IM	SIDLINGER MD,ROBERT L, 1500 SW 10TH, 66606 354-6883 49 M 1902 NEO
ROSS MD,JACK L, MENNINGER FD BOX 829, 66601 273-7500 32 M 4812 63 P	SIMPSON MD,WILLIAM S, MENNINGER FD BOX 829, 66601 273-7500 24 M 6001 63 P
ROTERT MD,LARRY, 1001 GARFIELD STE 301, 66604 233-4256 38 M 3005 77 U	SISK MD,PHILLIP B, 1001 HORNE STE 310, 66604 234-3451 32 M 1803 64 R
ROY MD,WILLIAM R, 634 MULVANE STE 104, 66606 233-1979 26 M 1606 54 ADM	SLAUGHTER ,JERRY, 1300 TOPEKA, 66612 235-2383 00 M
RUNNELS MD,JOHN B, 901 GARFIELD, 66606 357-6171 35 M 1902 72 NS	SMITH MD,LEO A, 4201 SW EMLAND DR # 2, 66606 08 M 3006 33 OO
RUPP MD,RICHARD J, 901 GARFIELD, 66606 354-9591 42 M 3841 75 CD	SNARR MD,JACK W, 1001 HORNE STE 310, 66604 234-3451 41 M 6201 77 DR
SANCHEZ MD,ROGELIO, 1516 W 6TH, 66606 232-1005 31 M 64901 70 U	SPEARMAN MD,JESSE L, 3320 SW 8TH, 66606 20 M 1902 54 OO
SARGENT MD,JOSEPH D, MENNINGER FD BOX 829, 66601 273-7500 32 M 2501 66 IM	SPENCER MD,MILLARD C, 1001 HORNE STE 310, 66604 234-3451 28 M 1902 55 R
SAYLOR MD,EDWARD H, 1125 SW GAGE, 66604 273-9813 39 M 1902 66 PD	SPENCER MD,WAYNE E, 1001 HORNE STE 103, 66604 233-9686 38 M 1902 65 GE
SAYLOR MD,LESLIE L, 1945 HIGH, 66604 07 M 1606 36 OO	STEIN MD,JOSEPH M, 901 GARFIELD, 66606 357-6171 24 M 3519 56 N
SAYLOR MD,MARK, 1710 SW 10TH #208, 66604 234-3211 37 M 1902 67 GS	STOCK MD,KARL W, 2740 BURLINGAME RD, 66611 13 M 2834 44 OO
SAYLOR MD,STEPHEN, 631 HORNE STE 340, 66606 232-9394 47 M 1902 74 FP	SUFI MD,M ASHRAF, 634 MULVANE #201A, 66604 354-8518 43 M 70402 77 IM

SWOGGER JR MD, GLENN, MENNINGER FD BOX 829, 66601 273-7500 35 M 3806 72 P	WANLESS MD, KIRK M, 1424 W EIGHTH, 66606 232-8188 44 M 2803 81 OTO
TAPPEN MD, DANIEL L, 2333 MAYFAIR PL, 66611 16 M 1902 41 OO	WARD MD, HOWARD N, 901 GARFIELD, 66606 354-9591 37 M 1606 70 HEM
TARGOWNIK MD, KARL K, 1218 W TENTH, 66604 232-1644 15 M 40710 59 OO	WARE MD, LUCILE M, MENNINGER FD BOX 829, 66601 273-7500 29 F 3501 66 P
TARNOWER MD, WILLIAM, MENNINGER FD BOX 829, 66601 273-7500 21 M 4802 53 P	WARRICK MD, DAVID ALAN, 620 SE MADISON, 66607 232-4566 49 M 3843 79 IM
TEMPERO MD, STEPHEN J, 1001 HORNE STE 310, 66604 234-3451 42 M 1606 72 R	WATERS MD, DALE A, 634 SW MULVANE STE 203, 66606 233-1690 41 M 5605 80 CDS
THOMS MD, NORMAN W, 901 GARFIELD, 66606 233-1710 34 M 2501 75 TS	WEAVER MD, WALTER D, 900 WASHBURN ST, 66606 233-3636 41 M 1902 70 OPH
THURSTON MD, DAVID E, 631 HORNE STE 200, 66606 233-7491 29 M 1902 55 ORS	WEBER MD, DARRELL J, 1710 W 10TH, 66604 233-2305 15 M 1902 44 FP
TIETZE MD, DENNIS D, 634 MULVANE STE 402, 66606 235-9545 50 M 1902 79 FP	WELSH MD, NANCY JANE, 2200 GAGE, 66622 272-3111 39 F 3840 84 IM
TOZER MD, RICHARD C, 1207 SW 29TH A-10, 66611 19 M 4102 53 OO	WILSON MD, MARVIN H, 1516 SW SIXTH, 66606 233-1747 38 M 1003 72 GS
TRAVIS MD, JOHN W, 15 PEPPERTREE LANE, 66611 29 M 1606 61 R	WOODS MD, ROBERT P, 8 PEPPERTREE LN, 66611 14 M 6701 50 N
TREGER MD, NEWMAN V, 1704 W 10TH, 66604 354-8761 16 M 1902 40 IM	YEH MD, ROBERT M, 2315 W 34TH, 66611 235-3451 47 M 24405 82 ANES
TUCKER MD, DONALD R, 620 SE MADISON, 66607 232-4566 31 M 1902 57 IM	YORKE JR MD, CRAIG H, 901 GARFIELD, 66606 357-6171 48 M 2401 80 NS
TUCKER MD, VIRGINIA L, BUREAU OF MAT & CHILD HLT, 66620 296-1205 30 F 1902 57 PD	YOUNG MD, PAUL E, 823 MULVANE, 66606 233-4927 42 M 2407 80 OPH
UHR MD, NATHANIEL, MENNINGER FD BOX 829, 66601 273-7500 00 M 3519 50 IM	YOUNG MD, THEODORE E, 2045 SE 29TH, 66605 267-0894 22 M 2307 51 PD
VAN SICKLE MD, GREGGORY J, 634 MULVANE STE 103, 66606 233-8508 49 M 1606 80 PD	ZACHARIAS MD, DAVID LLOYD, 1500 W TENTH, 66606 354-6870 26 M 1902 53 PATH
VANDE GARDE MD, LARRY D, 800 LINCOLN, 66606 233-5101 41 M 1803 72 OBG	ZERBE MD, KATHRYN, BOX 829, 66601 273-7500 51 F 4113 79 P
VASU MD, M ANDRE, 901 GARFIELD, 66606 233-1710 44 M 2407 85 CDTs	ZIMMERMAN MD, WILLIAM H, 1551 SW WESTOVER RD, 66604 20 M 3006 56 OO
VOGEL MD, STANLEY J, 901 GARFIELD, 66606 354-9591 44 M 2802 78 ON	
VOTH MD, ERIC A, 901 GARFIELD, 66606 354-9591 55 M 1902 84 IM	
WALIA MD, JAG M, 2200 W TENTH, 66604 234-8601 50 M 49515 84 FP	
WALLACE MD, LEO F, 5500 W 24TH, 66614 17 M 1902 41 OO	
WALLS MD, WILLIAM J, 1001 HORNE STE 310, 66604 234-3451 39 M 2834 72 DR	
WALZ MD, ROYCE C, 1710 W 10TH STE 205, 66604 234-2676 27 M 15407 62 P	
WALZ MD, THOMAS J, C/O ROYCE WALZ, 66604 94 M 1902 21 OO	

TOWANDA — 316
(Sedgwick County Medical Society)

NYBERG MD, FREDRIK F, ROUTE 1, 67144
22 M 2101 47 OO

TRIBUNE — 316
(Southwest Kansas Medical Society)

WERNER MD, WILLARD F, , 67879
376-4251
24 M 1902 52 FP

ULYSSES — 316 **(Southwest Kansas Medical Society)**

BREWER MD,MARSHALL A, PO BOX 687, 67880
356-1261
19 M 1902 46 FP

TILLOTSON MD,DON R, BOX 687, 67880
356-1261
32 M 1902 66 FP

VALLEY CENTER — 316 **(Sedgwick County Medical Society)**

DANIELS MD,ROBERT M, BOX 128, 67147
838-2794
24 M 1902 54 FP

MEANS MD,MILA LEE, RR 1 BOX 100, 67147
685-8231
56 F 1902 83 FP

WILSON MD,ROBERT L, RR 1, 67147
685-2563
30 M 1902 57 EM

WAKEENEY — 913 **(Central Kansas Medical Society)**

HAMILTON MD,JAMES J, MED CTR 323 RUSSELL, 67672
743-2124
30 M 1902 55 FP

LOCKE MD,MARLIN K, 323 RUSSELL, 67672
743-2124
56 M 1902 FP

WAMEGO — 913 **(Pottawatomie County Medical Society)**

BORGENDALE MD,LLEWELLYN V, 507 ELM PO BOX 7, 66547
456-2291
29 M 1902 61 FP

BRADEN MD,BILL L, PO BOX 7, 66547
456-2291
31 M 1902 61 FP

CLARK MD,LAURENCE A, 507 ELM, 66547
456-2291
12 M 1902 42 FP

WELCH MD,MAURA S, BOX 50, 66547
456-9202
50 F 1902 78 OBG

WIGGLESWORTH MD,ANNE, HWY 24 PO BOX 50, 66547
456-9202
40 F 1902 79 OBG

WASHINGTON — 913 **(Northeast Kansas Medical Society)**

HODGSON MD,DAVID K, 107 E THIRD, 66968
325-2259
49 M 1902 80 FP

WATHENA — 913 **(Northeast Kansas Medical Society)**

PETERSON JR MD,EVAN A, 324 ST JOSEPH BOX 98, 66090
989-3122
24 M 1803 56 FP

WELLINGTON — 316

ANDERSON MD,LARRY R, 1323 NORTH A, 67152
326-3301
43 M 1902 74 FP

COLE MD,WARD M, 110 N JEFFERSON, 67152
326-7221
08 M 1902 36 FP

MCCORMICK MD,EUGENE CARL, SECURITY STATE BANK BLDG, 67152
326-3914
31 M 1902 56 IM

NALDOZA JR MD,FAUSTINO M, 1323 NORTH A STE A, 67152
326-8171
38 M 74801 74 GS

PEDRAZA MD,HERNANDO, PO BOX 476, 67152
326-5026
28 M 26404 72 R

RATTENNE MD,MITZI E, 1323 NORTH A, 67152
326-3301
55 F 1902 85 FP

WEIGAND MD,JOEL T, 1323 NORTH A, 67152
326-3301
43 M 1902 71 FP

WESTMORELAND — 913 **(Pottawatomie County Medical Society)**

DECHAIRO MD,THOMAS, DECHAIRO HOSP, 66549
457-3311
13 M 1902 36 FP

MINGES MD,TIMOTHY J, 208 N 1ST, 66549
457-3311
54 M 1902 85 GP

WICHITA — 316 **(Sedgwick County Medical Society)**

ABAY MD,EUSTAQUIO O, 818 N EMPORIA STE 301, 67214
267-5800
49 M 74801 NS

ABBAS MD,DILAWER H, 1515 S CLIFTON APT 360, 67218
686-2831
45 M 70402 77 N

ACEVEDO MD,ALFREDO, 959 N EMPORIA STE 205, 67214
265-4701
40 M 73701 81 CDTs

AGUSTIN MD,CONRADO M, 1035 N EMPORIA STE 165, 67214
267-3389
38 M 74807 74 OBG

AHLSTRAND MD,RICHARD A, 3243 E MURDOCK STE 104, 67208
685-2711
41 M 3005 75 R

ALDOROTY MD,NEIL, 3243 E MURDOCK STE 400, 67208
686-7351
46 M 64914 83 P

ALEXANDER MD,ELIZABETH, UKSM WICHITA, 67214
261-2607
46 F 1902 78 FP

ALFONSO MD,MANUEL, 3311 E MURDOCK, 67208
689-9445
37 M 84710 72 ANES

ALLEN EXEC DIR ,DWIGHT, MED SOC OF SEDGWICK CO, 67211
683-7557
00 M

ALLEN MD,PHILLIP M, WESLEY MED CTR 550 N HILLSIDE, 67214
688-2838
27 M 2401 81 PATH

ALMONTE MD,PRISCILLA C, 1128 S CLIFTON, 67218
684-7251
44 F 74801 78 ANES

ALMONTE MD,RODOLFO O, 1515 S CLIFTON STE 480, 67218
686-3791
39 M 74801 78 OBG

AMMAR MD,ALEX D, 818 N EMPORIA STE 200, 67214
263-0296
51 M 5101 81 GPVS

AMSTUTZ MD,SAMUEL W, 655 N WOODLAWN, 67208
684-5158
53 M 1601 OPH

ANDERSON MD,DAVID J, 3243 E MURDOCK STE 401, 67208
686-7327
54 M 1902 84 ANES

ANDERSON MD,JAMES D, 3243 E MURDOCK STE 500, 67208
684-0251
57 M 1902 84 IM

ARGOSINO MD,RODOLFO, 1148 S HILLSIDE, 67211
683-6506
40 M 74801 77 GS

ARTZ MD,TYRONE D, 1125 N TOPEKA, 67214
267-0362
41 M 1803 74 ORS

AUNINS MD,JOHN, 4853 HEMLOCK, 67216
524-6805
28 M 4706 58 FP

BACHMAN MD,GREG R, 3311 E MURDOCK, 67208
689-9111
56 M 1902 86 ANES

BACKES MD,DAVID J, 851 N HILLSIDE, 67214
683-1371
48 M 1720 83 U

BAMMEL MD,BRUCE, 3311 E MURDOCK, 67208
689-9234
52 M 2507 82 OBG

BARBA JR MD,ANTONIO P, 1035 N EMPORIA STE 280, 67214
264-2301
34 M 74807 76 OBG

BARBA MD,ESTRELLA G, 1035 N EMPORIA STE 280, 67214
264-2301
41 F 74802 80 CHP

BARKER MD,BENJAMIN W, 6405 E KELLOGG #23, 67207
18 M 1902 51 OO

BARKER MD,PATSY, 818 N EMPORIA STE 303, 67214
265-3774
49 F 64914 82 PD

BARNETT MD,ARNOLD M, 3333 E CENTRAL STE 602, 67208
685-2561
32 M 83601 73 N

BARTAL MD,ELY, 905 N EMPORIA BOX 3298, 67201
262-7598
45 M 39607 81 ORS

BARTLETT MD,WAYNE C, 13 HAMPTON RD, 67207
07 M 1601 36 OO

BASS II MD,ORAL E, 851 N HILLSIDE, 67214
685-1371
40 M 2803 76 U

BASSELL MD,G M, BOX 782438, 67278
685-4389
46 M 14303 82 ANES

BATES MD,MICHAEL D, 2703 E CENTRAL, 67214
685-6521
48 M 3005 75 OBG

BATTISTE MD,CYNTHIA, 3333 E CENTRAL STE 416, 67201
681-2021
00 F PDC

BAUMAN MD,M LEON, 1629 UNIVERSITY, 67213
01 M 1902 44 OO

BAUMANN MD,PAUL A, 3333 E CENTRAL STE 214, 67208
688-2920
32 M 5605 68 R

BEAMER MD,LARRY R, 818 N EMPORIA STE 200, 67214
263-0296
52 M GS

BEBAK MD,DONALD M, 2322 E CENTRAL, 67214
263-6186
32 M 3515 72 ANES

BECK MD,CHARLES W, 1515 S CLIFTON STE 215, 67218
687-9961
46 M 301 80 IM

BECKER MD,KARL E, 818 N EMPORIA STE 307, 67214
264-9476
43 M 2307 78 ANES

BETHEL MD,CHANDLER S, 6611 E CENTRAL, 67206
682-6559
34 M 1902 60 IM

BIERMANN MD,HENRY J, 425 E MURDOCK, 67214
265-6287
27 M 3006 52 GS

BIERMANN MD,WILLIAM J, 1435 LIEUNETT, 67203
04 M 3006 29 OO

BIGONGIARI MD,LAWRENCE R, 929 N ST FRANCIS, 67214
268-5905
44 M 1611 R

BINGAMAN MD,ROBERT W, 7111 E 21ST, 67206
682-1053
47 M 3901 73 GS

BINYON MD,KERNIE W, BOX 8125, 67208
684-2819
24 M 1902 56 FP

BLACKMAN MD,JACQUES D, 3311 E MURDOCK, 67208
689-9111
51 M 1902 77 FP

BLAYLOCK MD,HOYT C, 79 VIA VERDE, 67230
21 M 1902 45 OO

BLOOM MD,BARRY THEIL, 550 N HILLSIDE, 67214
688-2360
56 M 1902 86 PD

BLOOM MD,RODNEY LAMONT, 406 E CENTRAL, 67202
265-0705
54 M 1902 80 IM

BLOXHAM MD,THOMAS J, 3311 E MURDOCK, 67208
689-9215
50 M 1803 80 PUD

BOEHM MD,DOUGLAS K, 3243 E MURDOCK STE 500, 67208
684-0251
52 M 1902 78 IM

BOEHM MD,MINDY M, 3333 E CENTRAL STE 408, 67208
682-0411
52 F 1902 81 PD

BOND MD,ROGER C, 3243 E MURDOCK STE 500, 67208
684-0251
40 M 5606 74 CD

BOXBERGER MD,GREGORY R, 818 N EMPORIA STE 407, 67214
264-8604
52 M 1902 CD

BOYD MD,Z REX, 120 S MAIZE RD #12, 67209
268-5000
26 M 3005 56 FP

BOYLE MD,HUGH H, 5425 E ELM, 67208
686-2193
33 M 3806 72 PATH

BRADLEY MD,JOHN G, 1131 S CLIFTON, 67218
689-4958
51 M 2803 FP

BRAKE MD,DAVID, 3243 E MURDOCK STE 104, 67208
685-2711
43 M 702 74 R

BRAUN III MD,WILLIAM T, 3243 E MURDOCK STE 104, 67208
685-2711
37 M 2802 67 R

BRAUN MD,KENNETH, 1431 BLUFFVIEW STE 211, 67218
683-4688
47 M 3519 78 OPH

BRAUN MD,THOMAS G, PO BOX 3841, 67201
685-2377
35 M 6001 76 N

BRECKBILL MD,DAVID L, 3333 E CENTRAL #214, 67208
685-1291
38 M 1902 65 R

BRINTON MD,E HOLMES, 3311 MURDOCK, 67208
689-9124
46 M 2101 77 GS

BRINTON MD,EDWARD S, 5051 W LINCOLN #8A, 67218
15 M 1611 46 OO

BROSIOUS MD,FRANK C, 3243 E MURDOCK STE 500, 67208
684-0251
25 M 1902 49 IM

BROWN MD,DAVID J, 425 E MURDOCK, 67214
265-6287
45 M 1902 72 GS

BROWN MD,MICHAEL P, 345 N HILLSIDE, 67214
683-6766
51 M 3007 78 OBG

BROWN MD,ROBERT L, 1515 S CLIFTON #120, 67218
682-1534
21 M 1902 49 FP

BROWN MD,RONALD C, 818 CARRIAGE PKWY, 67208
685-8231
47 M 2803 74 FP

BROWN MD,RONALD L, 1128 S CLIFTON, 67218
684-7251
45 M 3901 72 ANES

BROWN MD,VAL J, 1802 N HYDRAULIC, 67214
265-1461
24 M 1003 49 FP

BROWN MD,VAL J JR., 1802 N HYDRAULIC, 67214
265-1461
53 M 1902 82 IM

BROWNING MD,WILLIAM H, 7077 E CENTRAL #17, 67206
16 M 1902 43 OO

BRUMMETT MD,RICHARD R, PO BOX 780008, 67278
681-1152
34 M 1902 65 FP

BUBECK MD,RALPH W, 3311 E MURDOCK, 67208
689-9396
36 M 1803 68 IM

BUCK JR MD,BEN H, 1515 S CLIFTON STE 480, 67218
684-1048
17 M 2834 44 TS

BURNEY II MD,WILLIAM W, 1755 N MADISON, 67214
264-8311
50 M 4707 80 IM

BURNEY MD,WILLIAM W, 1755 N MADISON, 67214
264-8311
17 M 1902 52 FP

BURPEE MD,JAMES F, 851 N HILLSIDE, 67214
685-1371
39 M 5605 71 U

BUTH MD,DENNIS K, 2916 E CENTRAL, 67214
684-5243
45 M 1902 73 IM

BUTIN MD,J WALKER, 3311 E MURDOCK, 67208
689-9313
23 M 1902 47 IM

BUTLER MD,DORIS C, 1431 S BLUFFVIEW #102, 67218
684-2329
48 F 1902 76 FP

BYRNE MD,JAMES PERRY, 818 N EMPORIA STE 200, 67214
263-0296
42 M 2101 79 TS

CABALLERO MD,RENATO M, 7200 W 13TH, 67212
721-1200
54 M 30807 86 FP

CALIENDO JR MD,DANIEL J, 550 N HILLSIDE, 67214
685-2563
41 M 1902 73 EM

CAMPION MD,MARY K, 1010 N KANSAS, 67214
261-2650
51 F 1902 83 IM

CANNON MD,MICHAEL W, 818 N EMPORIA #403, 67214
262-4467
50 M 1902 82 ON

CAPPER MD,STANLEY L, 3311 E MURDOCK, 67208
689-9206
37 M 1803 70 D

CARLSON MD,TERRY S, 550 N HILLSIDE, 67214
688-2826
50 M 3006 79 PATH

CASTELLANI MD,SAM, 1010 N KANSAS PSY DEPT, 67214
261-2647
41 M 2507 P

CAUBLE MD,WILBUR G, PO BOX 20343, 67208
12 M 2834 46 OO

CAUGHLIN MD,GERALD MICHAEL, 427 N HILLSIDE, 67214
683-7200
55 M 4812 83 ANES

CAWLEY MD,LEO P, 60 VIA VERDE, 67230
688-2836
22 M 3901 57 PATH

CHANEY MD,ERNIE J, 1131 S CLIFTON, 67218
689-5500
27 M 1902 56 FP

CHANG MD,FREDERIC C, 818 N EMPORIA STE 200, 67214
263-0296
35 M 2401 75 GS

CHARD MD,FREDERICK H, 255 S HILLSIDE, 67230
15 M 5605 48 OO

CHAVEZ MD,STEVE, 3333 E CENTRAL STE 408, 67208
682-0411
55 M 1902 85 PD

CHI MD,IL-SUNG, BOX 782438, 67278
263-1574
41 M 58302 81 ANES

CHO MD,SECHIN, UKSM - WICHITA, 67214
261-2631
47 M 58302 77 PD

CHOPRA MD,RAMAN, 3333 E CENTRAL #201, 67208
685-5271
52 M 49536 78 PD

CHRISTMAN JR MD,CARL, 550 N LORRAINE, 67214
685-0559
48 M 4802 75 OBG

CLAIBORNE MD,RICHARD A, 3243 MURDOCK STE 500, 67208
684-0251
55 M 1902 80 IM

CLARK MD,COURTNEY, 1128 S CLIFTON, 67218
684-7251
30 M 1902 56 ANES

CLIFTON MD,H DAVID, 3600 E HARRY, 67218
689-5050
41 M 401 70 R

CLINE MD,BYRON W, 550 N LORRAINE, 67214
685-0559
51 M 4802 78 OBG

COATS MD,BARBARA S, 222 S RIDGE RD, 67209
945-0142
57 F 1902 84 FP

COHEN MD,JUSTIN THOMAS, 655 N WOODLAWN, 67208 684-5158 47 M 2803 78 OPH	DE BAKKER MD,JAN B, 1035 N EMPORIA STE 150, 67214 263-4903 25 M 5104 66 GS
COHLMIA MD,JERRY B, 818 N EMPORIA STE 310, 67214 263-5891 43 M 1902 71 IM	DE HART MD,ARTHUR DONIVA, 2703 E CENTRAL, 67214 685-1277 50 M 4804 78 OBG
COLEMAN MD,THOMAS J, 959 N EMPORIA, 67214 265-0749 18 M 3545 54 IM	DEJONG MD,DAVID C, PO BOX 12667, 67279 268-5424 33 M 2501 71 PATH
COLLIER MD,HAROLD W, 1515 S CLIFTON STE 260, 67218 683-5008 45 M 1902 72 ANES	DELMORE MD,JAMES E, 3243 E MURDOCK LEVEL B, 67208 681-0251 50 M 4804 80 GYN
CONCEPCION JR MD,EUGENIO S, 1515 S CLIFTON STE 480, 67218 684-1048 39 M 74802 74 CD	DEMOSSE MD,ELEANOR P, 3333 E CENTRAL STE 407, 67208 682-5591 42 F 74802 77 PD
CONRRARDY MD,PETER A, 818 N EMPORIA #101, 67214 683-1574 42 M 515 76 ANES	DIRKSEN MD,HANS C, 550 N HILLSIDE, 67214 688-2360 47 M 6001 81 NEO
COOK MD,DONALD RAY, 315 N HILLSIDE, 67214 686-3392 42 M 2012 72 FP	DOAN MD,TRINAH, 959 N EMPORIA STE 2 B, 67214 267-5580 32 M 94101 82 GP
COOK MD,G EDWARD, 8902 SUMMERFIELD, 67206 42 M 401 69 OO	DOEBLIN MD,P LAURENCE, 3333 E CENTRAL STE 214, 67208 685-1291 40 M 1002 82 R
COOPER MD,M KENT, 818 N EMPORIA STE 307, 67214 264-9476 54 M 1902 80 ANES	DOLAN JR MD,PHILIP JARVIS, 3311 E MURDOCK, 67208 689-9241 47 M 2105 79 GE
COSSMAN MD,F PRICE, 851 N HILLSIDE, 67214 685-1371 28 M 1902 57 U	DONATELLE MD,EDWARD P, UKSM WICHITA, 67214 261-2607 22 M 2604 79 FP
COWLES MD,GORDON T, 3333 E CENTRAL STE 704, 67208 683-2661 32 M 1902 59 OBG	DONLEY MD,JAMES L, 3101 E NINTH, 67208 684-0201 46 M 1902 73 P
CRANE MD,DAVID D, 929 N ST FRANCIS, 67214 268-5414 34 M 2501 73 PATH	DONNELL MD,JAMES M, P O BOX 9544, 67277 687-4421 28 M 1902 55 FP
CRONIN MD,DONALD J, 3311 E MURDOCK, 67208 689-9227 16 M 2604 48 OO	DONNELL MD,JAMES M, 929 N ST FRANCIS, 67214 268-5908 28 M 1902 55 FP
CROW MD,ERNEST W, 3243 E MURDOCK STE 500, 67208 684-0251 20 M 1902 44 CD	DOUTHIT MD,DOUGLAS DAVID, 550 N LORRAINE, 67214 685-0559 53 M 4802 80 OBG
CROWLEY MD,EDWARD X, 5 PARK AVE, 67206 14 M 1643 45 OO	DRAKE MD,RALPH L, 4422 E 3RD, 67208 99 M 4102 37 OO
CUMMINGS MD,RICHARD J, 427 N HILLSIDE, 67214 686-6608 32 M 1902 57 OTO	DRAZEK MD,GEORGE, 3311 E MURDOCK, 67208 689-9316 50 M 3506 81 OPH
DAKHIL MD,SHAKER R, 818 N EMPORIA STE 403, 67214 262-4467 50 M 60501 80 IM	DRAZEK MD,JANE K, 3400 E GRAND, 67218 689-4774 49 F 3506 81 P
DANBY MD,JOHN H, 925 N EMPORIA, 67214 265-2876 29 M 35205 83 FP	DREVETS MD,CURTIS C, 3311 E MURDOCK, 67208 689-9178 30 M 1902 56 IM
DARRAH MD,JOY N, 2020 N WOODLAWN ST. 570, 67208 681-1827 49 F 1902 77 R	DUICK MD,GREGORY, PO BOX 47669, 67201 265-1308 46 M 1643 77 CD
DAVIDSON MD,HARRY T, 1315 N WEST ST #E, 67203 87 M 3802 13 OO	DURANO MD,ANTONIO C, 959 N EMPORIA STE 401, 67214 263-7893 29 M 74807 65 U
DAVIS MD,PAUL H, 7111 E 21ST, 67206 684-2851 47 M 3901 73 FP	DYER MD,VERNON E, 3311 E MURDOCK, 67208 689-9234 36 M 301 77 OBG
DAVIS MD,RONALD B, 3420 E PAWNEE, 67218 685-2153 46 M 1902 73 FP	ECKERT MD,WILLIAM G, 7006 E TENTH, 67206 685-7612 26 M 3519 67 PATH
DAVISON MD,JOE D, 8200 W CENTRAL #1, 67212 721-4544 54 M 3901 84 FP	EDWARDS MD,MANIS C, 3333 E CENTRAL STE 704, 67208 683-2661 33 M 3005 65 OBG
DAY MD,HOWARD, 818 N EMPORIA STE 310, 67214 263-5891 48 M 1902 76 NEP	EGBERT MD,ANNE MARSH, UKSM WICHITA, 67214 261-2650 54 F 3840 80 IM

EGELHOF MD,RICHARD H, 222 S RIDGE RD, 67209

945-0142
45 M 1902 75 FP

ENOCH MD,ROLLAND, 315 N HILLSIDE, 67214

681-0423
49 M 64914 78 FP

ERKEN MD,RONALD V, WICHITA PSY CTR PO BOX 8037, 67208

684-0201
29 M 2834 62 P

ERNST MD,TARI MAE, 818 CARRIAGE PKWY, 67208

685-8231
56 F 3005 FP

ESTEP MD,THOMAS H, 818 N EMPORIA STE 200, 67214

263-0296
51 M 6002 82 CD

EVANS MD,FARRIS D, 521 RUTLAND RD, 67206

05 M 1902 32 OO

EVANS MD,JOHN F, 5628 POLO, 67208

688-2360
42 M 2803 71 MFM

EVANS MD,ROGER WILLIAMS, 3311 E MURDOCK, 67208

263-5889
39 M 1902 65 CD

EYSTER MD,ROBERT L, 3243 E MURDOCK STE 200, 67208

685-1491
47 M 3901 74 ORS

FARHA MD,GEORGE J, 818 N EMPORIA STE 200, 67214

263-0296
27 M 2101 64 GS

FARHA MD,S JIM, 818 N EMPORIA SUITE 200, 67214

263-0296
31 M 1001 65 TS

FARLEY MD,JAMES A, ST JOSEPH MEDICAL CENTER, 67218

689-5671
50 M 1902 82 PATH

FEAREY MD,ALAN J, 3311 E MURDOCK, 67208

689-9410
53 M 1902 80 IM

FERRELL MD,DONALD P, 1520 S CLIFTON, 67218

689-5775
36 M 3901 69 EM

FERRIS MD,BRUCE G, 825 N HILLSIDE, 67214

688-7500
43 M 1902 70 PS

FEUILLE JR MD,EDMOND G, 212 N HILLSIDE, 67214

682-4572
50 M 4802 76 OBG

FIELDS D.O.,STEPHEN, 7200 W 13TH, 67212

721-1200
42 M 2878 73 FP

FINLEY MD,DENNIS R, 1035 N EMPORIA STE 180, 67214

262-7429
36 M 1606 71 ORS

FISHER MD,RAY F, 3243 E MURDOCK STE 500, 67208

684-0251
49 M 1902 77 IM

FITZGERALD MD,EDWARD J, 3600 E HARRY, 67218

689-5050
22 M 3006 50 R

FITZIG MD,SANFORD, 3311 E MURDOCK, 67208

689-9185
46 M 4102 79 U

FLEMING MD,FORNEY W, 3243 E MURDOCK #200, 67208

685-1491
43 M 4802 75 ORS

FLOWERS JR MD,CLELL B, 855 N HILLSIDE, 67214

685-1381
22 M 1902 55 FP

FORD MD,CHARLES R, 232 S MAIZE RD, 67209

722-0568
38 M 1902 64 OPH

FORSTER JR MD,LOUIS G, 925 N EMPORIA, 67214

265-2876
47 M 1902 74 FP

FOWLER MD,ROBERT J, 3311 E MURDOCK, 67208

689-9236
37 M 2802 70 IM

FRANCIS MD,NORTON L, 55 VIA ROMA, 67230

10 M 3005 46 OO

FRANCISCO MD,DAN A, 3243 MURDOCK STE 500, 67208

684-0251
40 M 1803 81 CD

FRANCISCO MD,LINDA L, 818 N EMPORIA STE 310, 67214

263-5891
47 F 1803 82 NEP

FRENCH MD,JAMES E, 1515 S CLIFTON #420, 67218

684-5237
53 M 3005 80 GS

FRENCH MD,JEROME E, 310 S HILLSIDE, 67211

684-2838
44 M 1103 82 OTO

FRITZEMEIER MD,WILLIAM H, 835 N HILLSIDE, 67214

685-4395
14 M 1902 41 D

FROMER MD,JOEL, 2627 E CENTRAL, 67214

684-0501
46 M 16501 81 A

FROMM MD,ARTHUR H, 315 N HILLSIDE, 67214

685-2281
37 M 1902 64 FP

FULTON MD,JOHN K, 236 S TERRACE DR, 67218

18 M 5605 50 OO

GALICHIA MD,JOSEPH P, 818 N EMPORIA STE 407, 67201

264-8604
42 M 1902 70 CD

GALVAN MD,ALONSO, 3243 E MURDOCK STE 500, 67208

684-0251
38 M 64906 72 IM

GARD MD,RAYMOND F, 7077 E CENTRAL #25, 67206

01 M 1902 81 OO

GEARY MD,ALICE L, 3311 E MURDOCK, 67208

689-9315
50 F 401 85 ANES

GENILO MD,AMANCIO C, 1520 S CLIFTON, 67218

689-5775
37 M 74801 77 EM

GENILO MD,CELESTE A, 3311 E MURDOCK, 67208

689-9445
39 F 74801 62 ANES

GEORGE MD,EARL F, 2146 N OLD MANOR, 67208

681-3320
35 M 1902 66 FP

GERBER MD,ALLEN D, 7111 E 21ST, 67206

682-1053
48 M 1902 78 GS

GILMARTIN MD,RICHARD C, 2620 E CENTRAL, 67214

685-2377
32 M 4112 77 PDN

GIVNER MD,DAVID, 2627 E CENTRAL, 67214

03 M 2301 57 OO

GOERING MD,RANDALL V, 1969 W 21ST, 67203

832-9024
58 M 1902 85 FP

GOLDBERG MD,HERBERT R, UKSM-WICHITA, 67214

261-2631
33 M 3508 64 PD

GONZALEZ MD,HIRAM, 3429 E DOUGLAS, 67218

681-1348
20 M 64901 71 P

GOODPASTURE MD, HEWITT C, 818 N EMPORIA STE 305, 67214 264-3505 43 M 1902 70 IM	HARRISON MD, PAUL BARRY, 3243 E MURDOCK STE 201, 67208 685-6222 49 M 1902 78 GS
GORDON MD, JAMES R, 3311 E MURDOCK, 67208 689-9260 53 M 1611 83 IM	HART MD, DILLIS L, 1515 S CLIFTON STE 300, 67218 688-0135 36 M 3901 67 GS
GOYLE MD, KRISHAN K, 1150 N ST FRANCIS, 67214 267-9906 34 M 49529 76 CD	HART MD, JOHN J, 3243 E MURDOCK STE 303, 67208 688-3070 53 M 74808 78 GP
GOYLE MD, VIMAL, 1150 N ST FRANCIS, 67214 267-9906 41 F 49529 76 OBG	HARTLEY MD, JAMES M, 818 CARRIAGE PKWY, 67208 685-8231 45 M 2604 79 FP
GRAUEL MD, CHARLES W, 8310 CHALET, 67207 684-6215 44 M 1902 71 ANES	HARTWELL MD, KIMBERLY, 855 N HILLSIDE, 67214 685-1381 56 F 1902 83 FP
GRAVES MD, JACK W, 610 RUTLAND, 67206 17 M 1902 42 OO	HARTWELL MD, RICK L, WESLEY MED CTR 550 N HILLSIDE, 67214 688-2222 83 M 1902 83 FP
GRAY MD, C LUCIEN, 3311 E MURDOCK, 67208 684-5171 21 M 1902 45 ENT	HARVEY MD, ROSEMARY B, 626 N BROADWAY STE B, 67214 268-8025 24 F 1902 49 ADM
GRAY MD, H TOM, 3610 E ENGLISH #102-B, 67218 19 M 401 55 OO	HASKINS MD, ROBERT J, 1131 S CLIFTON, 67218 689-5500 46 M 1902 75 FP
GREENBERG MD, CRAIG P, 3311 E MURDOCK, 67208 689-9373 56 M 1643 END	HASSAN MD, RIZWAN U, 1515 S CLIFTON STE 360, 67218 686-2831 47 M 70404 70 N
GREER MD, JAMES A, 3311 E MURDOCK, 67208 689-9227 43 M 1611 78 OTO	HATTRUP MD, RICHARD J, 1148 S HILLSIDE, 67211 682-9477 31 M 3006 59 FP
GRENE MD, ROBERT BRUCE, 655 N WOODLAWN, 67208 684-5158 53 M 1902 OPH	HAWLEY MD, RAYMOND G, 929 N ST FRANCIS, 67214 268-5559 39 M 1902 66 PATH
GRILLOT MD, FLOYD B, 1515 S CLIFTON STE 150, 67218 684-0243 18 M 1902 51 FP	HAYES MD, WILLIAM L, 3243 E MURDOCK STE 500, 67208 684-0251 28 M 1902 53 CD
GROHS MD, HEINZ K, 550 N HILLSIDE, 67214 688-2840 42 M 15407 73 PATH	HAYNES MD, DEBORAH G, 2020 N WOODLAWN STE 550, 67208 683-4334 54 F 1902 80 FP
GRUSHNYS MD, ARNOLD, 3311 E MURDOCK, 67208 689-9445 19 M 40721 70 ANES	HAYS MD, THOMAS H, 7111 E 21ST, 67206 684-2851 49 M 1902 76 FP
GSELL MD, GEORGE F, 32 MISSION RD, 67206 07 M 1601 34 OO	HEALY MD, PATRICK M, 818 N EMPORIA STE 101, 67214 263-1574 56 M 3006 86 ANES
GUTHRIE MD, RICHARD A, 1515 S CLIFTON STE 250, 67218 687-3100 35 M 2803 73 PD	HENDRICKS MD, RANDALL L, 905 N EMPORIA BOX 3298, 67201 262-7598 54 M 1902 87 ORS
HABASHY MD, SHAWKY N F, 8404 W 13TH STE 230, 67212 722-6109 43 M 33004 80 OBG	HENNING MD, CHARLES E, 320 N HILLSIDE, 67214 682-3221 37 M 1902 64 ORS
HAGAN MD, C THOMAS, UKSM WICHITA, 67214 261-2622 16 M 3006 42 IM	HENWOOD MD, JOHN R, 7602 E HARRY, 67207 682-7411 52 M 3901 85 FP
HAGAN MD, FRANCIS J, 14817 E 29TH NORTH, 67228 13 M 3006 39 OO	HERED MD, JOHN, 1515 S CLIFTON #320, 67218 686-7222 41 M 2802 73 N
HAGAN MD, ROBERT C, 3311 E MURDOCK, 67208 689-9306 52 M 1902 82 GE	HERSHBERGER DO., GROVER, 1245 N WEST ST, 67203 945-6910 47 M 2878 80 GP
HAGAN MD, STEPHEN F, 1250 W MAPLE, 67213 262-1057 53 M 2802 81 PUD	HERSHORN MD, SIMON E, 3333 E CENTRAL STE 214, 67208 685-1291 22 M 1902 46 R
HALL MD, J ROGER, 1515 S CLIFTON STE 310, 67218 685-5227 42 M 4802 76 OPH	HESSE MD, JAMES F, 818 CARRIAGE PKWY, 67208 685-8231 54 M 1902 FM
HARMS MD, EDWIN M, 5623 POLO DR, 67208 06 M 3901 36 OO	HETT MD, EDWARD J, 2302 N COOLIDGE, 67204 832-9024 55 M 1902 82 FP
HARRIS MD, FRANK H, 2026 N OLD MANOR, 67208 09 M 1001 39 OO	HINSHAW JR MD, CHARLES T, 1133 E SECOND, 67214 262-0951 32 M 1902 59 PATH

HINSHAW MD,ALFRED H, 1655 GEORGETOWN #307, 67218

07 M 1902 33 OO

HINSHAW MD,CHARLES T, 256 N BLECKLEY DR, 67208

99 M 4705 29 OO

HIZON MD,RAMON R, 929 N ST FRANCIS, 67214

268-5906
38 M 74801 62 DR

HODSON MD,HERVEY R, 8809 E HARRY APT 909, 67207

03 M 1606 31 OO

HOFFMAN MD,JAMES E, UKSM WICHITA, 67214

261-2650
38 M 1902 85 IM

HOLDEN JR MD,RAYMOND F, 262 S BROOKSIDE, 67218

10 M 2802 56 OO

HOLMES MD,JED, 7111 E 21ST, 67206

684-2851
53 M 3005 79 FP

HORBELT MD,DOUGLAS V, 3243 E MURDOCK L-B, 67208

681-0251
47 M 4802 73 OBG

HOUSHOLDER MD,DANIEL FAIR, 7705 KILLARNEY CT, 67206

268-5910
43 M 1902 71 NM

HOUSHOLDER MD,MARTHA S, 835 N HILLSIDE, 67214

685-4395
46 F 1902 73 D

HOUSTON MD,THOMAS P, 1010 N KANSAS, 67214

268-2607
51 M 2701 FP

HOWARD MD,DONALD O, 82 VIA VERDE, 67230

11 M 1902 38 OO

HUEBERT MD,DEAN A, 5025 E KELLOGG, 67218

682-1534
22 M 1902 46 FP

HUGHES MD,JOHN D, 818 N EMPORIA STE 200, 67214

263-0296
51 M 1902 81 GS

HULTGREN MD,MYRON K, 450 N ARMOUR, 67206

685-1382
41 M 1902 69 FP

HUME MD,JOSEPH W, 3333 E CENTRAL STE 504, 67208

685-2223
38 M 1902 70 OBG

HUMMER MD,LLOYD M, 3311 E MURDOCK, 67208

689-9323
32 M 3901 66 IM

HUND MD,LARRY R, 3333 E CENTRAL STE 408, 67208

682-0411
52 M 1902 81 PD

HUSTEAD MD,ROBERT F, 2401 N PERSHING, 67220

683-7200
28 M 801 63 ANES

HUYCKE MD,EDWARD J, VA HOSPITAL, 67211

685-2221
28 M 1902 53 IM

HYNES MD,HENRY E, 818 N EMPORIA STE 403, 67214

262-4467
35 M 53902 65 HEM

IBARRA MD,J LUIS, 959 N EMPORIA STE 404, 67214

262-1853
20 M 64901 59 P

IDBEIS MD,BADR, 1035 N EMPORIA #290, 67214

262-7662
47 M 87501 80 TS

ISAACS MD,JUANITA J, 3101 E 9TH, 67208

684-0201
43 F 2101 84 P

JACKSON MD,CHARLES R, 1035 N EMPORIA STE 135, 67214

263-0812
27 M 1606 60 GS

JAMES MD,DONALD L, 1301 N WEST, 67203

945-5245
42 M 3901 81 OTO

JAWADI MD,JAMEELA HUSAIN, 6713 E 32ND, 67226

832-1185
50 F 49521 80 PD

JEHAN MD,SAYED S, 635 N MAIN, 67203

268-8036
33 M 70403 75 P

JENNEY MD,CHARLES B, 818 N EMPORIA SUITE 200, 67214

263-0296
34 M 2834 68 GS

JENSEN MD,DARAN L, 3333 E CENTRAL SUITE 301, 67208

685-7234
52 M 3005 80 OBG

JESTER MD,SHELBY L, 818 N EMPORIA STE 307, 67214

268-6189
43 F 4102 78 ANES

JOHNSON MD,CAROL ANN, 3243 E MURDOCK SUITE 303, 67208

688-3070
49 F 1902 78 FP

JOHNSON MD,CAROLYN K, WESLEY MED CTR 550 N HILLSIDE, 67214

688-2360
48 F 1902 81 NEO

JOHNSON MD,GEORGE K, UKSM WICHITA, 67214

261-2622
40 M 1205 79 IM

JOHNSON MD,MARGARET J, 3311 E MURDOCK, 67208

689-9344
54 F 4804 D

JOHNSON MD,THOMAS E, 3333 E CENTRAL STE 214, 67208

685-1291
41 M 1643 75 R

JONES MD,RODNEY, 3619 E KELLOGG, 67212

687-2527
56 M 1803 84 ANES

JOST MD,GARY D, 212 N HILLSIDE, 67214

685-5211
51 M 1902 78 GS

JUDILLA JR MD,FRANCISCO, 2322 E CENTRAL, 67214

263-6186
44 M 74801 76 ANES

KADISON MD,HERBERT I, 929 N ST FRANCIS, 67214

268-5916
44 M 1611 75 R

KAHN MD,DAVID M, 3311 E MURDOCK, 67208

689-9316
54 M 3843 85 OPH

KARDATZKE MD,E STANLEY, 151 N MAIN STE 450, 67202

681-1152
39 M 1720 65 FP

KARDATZKE MD,JON K, 8200 W CENTRAL STE 1, 67212

721-4544
36 M 1720 65 FP

KASHA MD,ROBERT L, 256 LOCHINVAR, 67207

11 M 2834 46 OO

KASSEBAUM MD,KENNETH G, 8901 E ORME, 67207

685-6381
34 M 1606 75 CHP

KAUFMAN MD,EUGENE E, 3243 E MURDOCK STE 200, 67208

685-1491
30 M 1902 56 ORS

KEENE MD,GEORGE H, 5025 E KELLOGG, 67218

682-1534
20 M 1902 49 GS

KELLER MD,JAMES P, 1431 S BLUFFVIEW STE 209, 67218

685-1284
48 M 1902 75 IM

KELLY MD, ROBERT W, 2212 E CENTRAL, 67214 265-0959 46 M 4802 73 OBG	KRUPKA MD, JOHN J, 818 N EMPORIA #201, 67214 263-0348 47 M 1642 79 NS
KENDALL MD, TOM E, 825 N HILLSIDE, 67214 688-7500 37 M 3901 70 PS	KUBINA MD, GLENN RICHARD, MID-KS ENT ASSN 310 S HILLSIDE, 67211 684-2838 47 M 3840 79 OTO
KENDRICK MD, J GILLERAN, 550 N HILLSIDE, 67214 688-2088 20 M 1902 47 ADM	KUMAR MD, ARUN, 3333 E CENTRAL #816, 67208 685-5326 50 M 49529 85 PD
KENNEDY MD, GERALD T, 2916 E CENTRAL, 67214 684-5243 35 M 1902 62 GE	KURTH MD, C JOSEPH, 200 S ROCK RD STE H, 67207 10 M 3006 37 OO
KEYES MD, MICHAEL J, 3101 E 9TH, 67208 684-0201 44 M 2101 84 P	KUTILEK MD, FRANK J, 6634 W CENTRAL, 67212 722-1200 30 M 1902 57 FP
KHICHA MD, GYANCHAND J, 818 N EMPORIA STE 200, 67214 263-0296 37 M 49530 73 TS	LAI MD, JENG Y, 959 N EMPORIA STE 205, 67214 265-4701 41 M 38502 77 TS
KHOORY MD, GEORGE H, 3333 E CENTRAL STE 416, 67208 681-2021 32 M 33002 75 PD	LANCE JR MD, JOHN F, PO BOX 8206, 67208 20 M 1902 45 OO
KIM MD, PAIK N, 3243 E MURDOCK SUITE 300, 67208 681-0736 33 M 58302 75 HEM	LATIMER MD, KATHERINE, 3243 E MURDOCK STE 401, 67208 686-7327 49 F 1205 78 ANES
KIMBLE MD, JAMES A, 3311 E MURDOCK, 67208 689-9316 45 M 702 78 OPH	LAUVER MD, MARY ANN, 818 N EMPORIA STE 303, 67214 265-3774 40 F 1902 75 PD
KIRK JR MD, E DAVID, 1431 S BLUFFVIEW DR STE 209, 67218 685-1351 34 M 1902 63 IM	LAWN MD, CLAUDIA A, 144 S HILLSIDE, 67211 685-3411 50 F 1902 77 R
KIRSCH MD, MARK A, 3243 E MURDOCK STE 401, 67208 686-7327 53 M 1902 85 ANES	LAWN MD, RAYMOND A, 715 N MISSION RD, 67206 683-8991 09 M 2604 49 AM
KISER MD, JOHN L, 3243 E MURDOCK STE 201, 67208 685-6222 37 M 2802 65 GS	LEE JR MD, EDWARD S, 2002 E 17TH, 67214 264-8273 09 M 4707 52 FP
KISER MD, WILLARD J, 1446 WILLOW RD, 67208 05 M 4705 34 OO	LEE MD, MARTIN W, 3243 E MURDOCK STE 300, 67208 681-0736 56 M 4814 86 ON
KITCHEN MD, ROBERT R, 3420 E DOUGLAS, 67208 685-2355 26 M 1902 52 CHP	LEE MD, R REX, 6155 E HARRY, 67218 685-2306 29 M 3901 55 FP
KLAFTA MD, LEONARD A, 3311 MURDOCK, 67208 689-9524 37 M 1611 87 NS	LEFFINGWELL MD, BRUCE L, 818 N EMPORIA #307, 67214 268-6189 57 M 1902 ANES
KLINGMAN MD, DIANE D, 2020 N WOODLAWN #550, 67208 683-4334 53 F 1902 80 FP	LEISY MD, JERALD W, 3310 E DOUGLAS STE 101, 67208 681-2937 42 M 1902 70 P
KNAPP MD, LESLIE E, 302 S CRESTWAY, 67218 96 M 1902 25 OO	LEITNER MD, YORAM B, 3311 E MURDOCK, 67208 689-9227 53 M 3519 82 OTO
KNAPP MD, M ROBERT, 810 N LORRAINE, 67214 685-2207 23 M 3519 55 ANES	LESKO MD, PAUL D, 905 N EMPORIA, 67214 262-7598 49 M 5605 ORS
KNEIDEL MD, THOMAS W, 732 N TOPEKA, 67214 267-1924 40 M 4101 70 ORS	LEVINE MD, WILLIAM R, UKSM-WICHITA, 67214 261-2647 42 M 1902 68 P
KNIGHT MD, LAURA C, 929 N ST FRANCIS, 67214 268-5922 42 F 502 DR	LEWIS MD, H. MICHAEL, 1035 N EMPORIA #290, 67214 262-7662 50 M 3840 CDS
KNIGHT MD, PHILIP J, 818 N EMPORIA STE 200, 67214 263-0296 42 M 502 82 PDS	LIES MD, RICHARD B, 3311 E MURDOCK, 67208 689-9131 42 M 1902 69 RHU
KOURI MD, SAMMY H, 3243 E MURDOCK STE 201, 67208 682-2911 33 M 3901 62 GS	LIN MD, JOE J, 929 N ST FRANCIS, 67214 268-5420 42 M 24404 72 PATH
KRAUSE MD, MAURICE D, 808 N EMPORIA, 67214 268-5908 43 M 1720 85 ON	LINHARDT MD, RONALD D, 3243 E MURDOCK STE 603, 67208 683-2655 36 M 2803 68 OBG
KREADY MD, JOHN L, 818 CARRIAGE PKWY, 67208 685-8231 48 M 1902 80 FP	LITTELL MD, JAMES A, ST FRANCIS R.M.C., 67214 268-5048 44 M 1902 72 EM

LITTLE MD,L GILBERT, 122 S WESTFIELD, 67209

99 M 401 28 P

LIVINGSTON D.O.,DOUGLAS R, 818 N EMPORIA STE 407, 67214

264-8604
52 M 2879 78 PUD

LOCKHART MD,JOSEPH G, PO BOX 20434, 67208

17 M 4113 52 OO

LOEFFLER MD,JAMES A, 400 N WOODLAWN STE 109, 67208

685-5375
36 M 3841 68 A

LOEWEN MD,HENRY H, 2142 W 17TH, 67203

03 M 1902 36 OO

LOEWEN MD,WILLIAM C, 8200 W CENTRAL STE 1, 67212

721-4544
41 M 1902 72 FP

LOGAN MD,GEOFFREY G, 212 N HILLSIDE, 67214

682-4572
31 M 14303 76 OBG

LOHNES JR MD,JOHN H, 3333 E CENTRAL #214, 67208

685-1291
55 M 1803 DR

LOSEE MD,JOHN M, 3243 E MURDOCK STE 401, 67208

686-7327
51 M 4301 82 ANES

LOVETT MD,PAUL A, 110 PATTON, 67208

09 M 1902 45 OO

LOW MD,HAROLD L, 201 S PERSHING, 67218

18 M 1902 44 OO

LUCAS MD,GEORGE L, 3311 E MURDOCK, 67208

689-9495
34 M 1001 84 ORS

LUDLOW MD,MICHAEL G, 8200 W CENTRAL, 67212

721-4544
56 M 1902 85 FP

LUEKEN MD,LUEKE B, 3311 E MURDOCK, 67208

689-9234
23 M 40723 63 OBG

LUNA MD,ANTHONY D, 3243 E MURDOCK STE 303, 67208

683-3070
54 M 1902 83 FP

LUZZATI MD,ENZO F, 6620 N GREENWICH RD, 67228

25 M 56119 65 OO

LYGRISSE MD,DANIEL V, 3311 E MURDOCK, 67208

689-9111
50 M 64914 82 FP

LYNCH MD,MARY A, 320 N HILLSIDE, 67214

682-3221
48 F 1002 81 FP

MADISON JR MD,WARD N, 3600 E HARRY, 67218

689-5668
37 M 3601 69 PATH

MAGIDSON MD,ELLIOTT ARTHUR, WESLEY MED CTR 550 N HILLSIDE, 67214

688-2824
43 M 1611 21 PATH

MAILMAN MD,GERSHOM, 1341 S BLUFFVIEW #117, 67218

685-6466
26 M 3519 57 ANES

MANDELBAUM MD,MARK A, 3311 E MURDOCK, 67208

689-9137
53 M 3901 83 N

MANNING MD,ROBERT T, UKSM WICHITA, 67214

688-2212
27 M 1902 54 IM

MANSOUR MD,BADIE S, 3243 E MURDOCK STE 401, 67208

686-7327
45 M 33002 76 ANES

MARSH MD,HENRY O, 905 N EMPORIA BOX 3298, 67201

262-7598
18 M 1611 46 ORS

MARTIN JR MD,GLEN E, 2322 E CENTRAL, 67214

20 M 1902 49 OO

MARYMONT JR MD,JESSE H, WESLEY MED CNTR 550 N HILLSIDE, 67214

688-2848
28 M 3515 64 PATH

MASTIO JR MD,GEORGE J, 3243 E MURDOCK STE 201, 67208

684-5235
25 M 1902 52 GS

MATASSARIN MD,FREDERICK W, 2011 PORTER,APT A-39, 67203

15 M 1902 37 U

MAWDSLEY MD,MICHAEL W, 2819 ORIOLE, 67204

261-2622
49 M 1902 75 PD

MCBOYLE MD,MARILEE, 818 N EMPORIA STE 200, 67214

263-0296
52 F 1902 78 GS

MCCLANAHAN MD,WARD A, 1515 S CLIFTON STE 130, 67218

684-8211
22 M 3005 49 ORS

MCCLELLAN MD,ERNEST L, 3243 E MURDOCK STE 401, 67208

686-7327
38 M 4802 73 ANES

MCCOY MD,C PATRICK, 3243 E MURDOCK STE 401, 67208

686-7327
53 M 1902 83 ANES

MCCOY MD,CHARLES P, 3333 E CENTRAL STE 301, 67208

17 M 3006 42 OO

MCCULLOUGH MD,JAMES P, WESLEY MED CTR 550 N HILLSIDE, 67214

688-2807
54 M 1902 83 PATH

MCDONOUGH MD,W DAVID, 3311 E MURDOCK, 67208

689-9239
48 M 3305 82 U

MCGUIRE MD,WILLIAM F, 3333 E CENTRAL STE 204, 67208

683-5655
17 M 4101 49 PD

MCKAY MD,ROBERT S, PO BOX 18748, 67218

685-4389
56 M 3901 84 ANES

MCMASTER MD, JOHN F, ST FRANCIS R.M.C., 67214

268-5048
54 M 2106 83 FP

MCMULLEN MD,BRUCE R, 1122 S CLIFTON, 67218

682-5012
53 M 4002 80 IM

MCNICKLE MD,GEORGE A, 222 S RIDGE RD, 67209

945-0142
49 M 1902 FP

MCQUEEN MD,DAVID ARNOLD, 905 N EMPORIA BOX 3298, 67201

262-7598
47 M 64914 77 ORS

MCRAE-DENNING MD,PATRICIA, 3311 E MURDOCK, 67208

689-9333
56 F 1902 83 IM

MEEK JR MD,JOSEPH C, UKSM-WICHITA, 67214

261-2635
31 M 1902 57 IM

MEEKER II MD,BRUCE P, 345 N HILLSIDE, 67214

686-3384
30 M 1902 59 OBG

MELEAN MD,JAIME, 1152 S CLIFTON, 67218

688-0321
40 M 17602 78 CD

MELHORN MD,J MARK, 8239 LIMERICK, 67206

267-1924
53 M 1902 82 ORS

MELHORN MD,KATHERINE J, 8239 LIMERICK, 67206 268-8302 55 F 1902 83 PD	MOORE MD,DENNIS F, 3311 E MURDOCK, 67208 689-9250 36 M 2101 64 HEM
MENAKER MD,JEROME S, 2703 E CENTRAL, 67214 16 M 1002 49 OO	MORGAN III MD,LOUIS S, 8030 E KELLOGG, 67207 683-3811 22 M 3901 49 FP
MENDIONES MD,L MARLENE, 2501 E CENTRAL, 67214 687-5733 45 F 1611 75 D	MORGAN MD,JAMES I, PO BOX 17007, 67217 522-2266 29 M 1606 56 FP
MENDIONES MD,RUPERTO D, 2501 E CENTRAL, 67214 682-6585 44 M 1611 76 IM	MORGAN MD,RANDALL J, 212 N HILLSIDE, 67214 682-4572 52 M 1902 OBG
MENEHAN MD,H JAMES, 2959 N ROCK RD, 67226 689-9442 26 M 1902 53 PD	MORROW MD,THOMAS F, 3310 E DOUGLAS, 67208 685-1443 21 M 5606 51 P
MENHUSEN D.O.,MONTY J, 3243 E MURDOCK STE 401, 67208 686-7327 48 M 1676 83 ANES	MOSIER MD,STANLEY JAY, 818 CARRIAGE PKWY, 67208 685-8231 42 M 1902 69 FP
MENKING MD,F W MANFRED, 3311 E MURDOCK, 67208 689-9336 34 M 40715 74 PD	MUELLER MD,VERNETTE A, 624 N ARMOUR, 67206 17 M 2802 42 OO
MENKING MD,SUSAN MARGARET, UKSM WICHITA, 67214 261-2631 41 F 3840 77 PD	MUETH MD,JOAN D, 7111 E 21ST, 67206 684-2851 53 F 2803 80 FP
MERCADER MD,MARIO S, 818 N EMPORIA STE 307, 67214 264-9476 43 M 74801 78 ANES	MULLINIX MD,JANICE M, 3333 E CENTRAL STE 601, 67208 687-5443 47 F 3006 77 N
MEREDITH MD,W TOM, 1035 N EMPORIA STE 105, 67214 263-7285 35 M 4812 69 IM	MURPHY MD,BARRY L, 3243 E MURDOCK STE 500, 67208 684-0251 45 M 1902 72 IM
MERRIFIELD MD,TERRY S, 818 CARRIAGE PKWY, 67208 685-8231 47 F 1002 76 FP	MURPHY MD,DUANE A, 3243 E MURDOCK STE 200, 67208 685-1491 32 M 1902 66 ORS
MERSHON MD,JAMES C, 933 N TOPEKA, 67214 263-5889 37 M 1803 70 CD	MURPHY MD,PATRICK L, 7150 E HARRY, 67207 687-2651 55 M 3901 82 FP
MESSNER MD,STAN A, 8200 W CENTRAL, 67212 721-4544 56 M 1902 84 FP	MURPHY MD,PAUL M, 3600 E HARRY, 67218 689-5050 28 M 3006 57 R
MEYER MD,WARREN E, 1515 S CLIFTON STE 420, 67218 684-5237 27 M 1606 58 GS	MURPHY MD,PAUL W, UKSM - WICHITA, 67214 261-2647 49 M 1902 83 P
MICHELBAACH MD,ALBERT P, 4815 E CENTRAL, 67208 684-5243 35 M 2101 66 IM	MURPHY MD,WILLIAM R C, 818 N EMPORIA STE 200, 67214 263-0296 43 M 1611 TS
MILFELD MD,DOUGLAS J, 818 N EMPORIA STE 200, 67214 263-0296 45 M 4804 79 TS	MURRAY MD,KENT B, UKSM-WICHITA, 67214 261-2650 47 M 3901 74 IM
MILLER MD,DAVID PATERSON, 7111 E 21ST N, 67206 684-2851 50 M 2803 78 FP	NELLIS MD,STEPHANIE F, 3311 E MURDOCK, 67208 689-9270 53 F 1902 81 IM
MILLER MD,DON E, 4145 E KELLOGG, 67218 20 M 2802 46 OO	NELSON JR MD,GUST H, 3600 E HARRY, 67218 689-5050 23 M 1902 46 DR
MILLER MD,TODD A, 8200 W CENTRAL, 67212 721-4470 55 M 1902 82 FP	NELSON MD,GERALD D, 825 N HILLSIDE, 67214 688-7500 34 M 1902 61 PS
MILLS MD,CHARLES D, 1140 S WATER, 67213 89 M 2002 16 OO	NELSON MD,RUSSELL ALAN, C/O WESLEY/PERINATAL, 67214 688-2360 18 M 1902 45 PD
MILLS MD,PHILIP R, 3243 E MURDOCK STE 202, 67208 683-6613 49 M 512 PM	NESMITH MD,LESLIE W, 530 N LORRAINE, 67214 683-5611 40 M 1902 67 OPH
MINNS MD,GAROLD O, UKSM-WICHITA DEPT OF MED, 67214 261-2650 51 M 1902 77 IM	NETHERTON MD,DAVID M, 7111 E 21ST, 67206 684-2851 55 M 2803 82 FP
MIRZA MD,MEDO, PO BOX 8147, 67208 686-6683 38 M 40733 73 PDS	NEWBY MD,JAMES P, 818 N EMPORIA STE 200, 67214 263-0296 34 M 1902 70 TS
MONTGOMERYSHORT MD,RUTH G, 1019 W 50TH NORTH, 67204 10 F 1902 37 OO	NEWSOM MD,F CARTER, 3310 E DOUGLAS, 67208 685-1443 18 M 1201 50 P

NIELSEN MD,MARY L, WESLEY MED CTR LAB DEPT, 67214
 688-2468
 47 F 1902 78 PATH

 NIXON MD,WILLIAM A, 3333 E CENTRAL STE 525, 67208
 683-6622
 16 M 1902 44 GS

 NORRIS MD,ROBERT P, 3311 E MURDOCK, 67208
 17 M 1902 43 OO

 NORTH MD,DORIS G, 1148 S HILLSIDE, 67211
 684-5257
 16 F 1902 47 FP

 NORTON MD,ROBERT K, 3311 E MURDOCK, 67208
 689-9235
 32 M 1001 67 PD

 NOWLIN MD,NANCY S, UKSM-WICHITA, 67214
 261-2650
 47 F 1902 75 IM

 OCHSNER MD,BRUCE B, 1100 N TOPEKA, 67214
 263-6273
 39 M 1902 66 OPH

 ODENHEIMER MD,BURTRAM J, 3311 E MURDOCK, 67208
 689-9137
 48 M 2105 73 N

 OLSON MD,DAN E, UKSM - WICHITA, 67214
 261-2650
 42 M 702 85 PM

 OLSON MD,DAN E, UKSM-WICHITA, 67214
 261-2650
 42 M 702 85 PM

 ORTH-BAALMAN MD,DIANE M, 8615 FRAZIER, 67212
 721-1866
 56 F 1902 83 PD

 OSBORNE MD,CONRAD C, 855 N HILLSIDE, 67214
 685-1381
 38 M 1902 68 FP

 OSIO MD,ANTONIO L, 4145 E KELLOGG, 67218
 682-6551
 41 M 26404 72 EM

 OSOBA MD,WILLIAM G, 2525 W 13TH, 67203
 943-9391
 25 M 2802 54 FP

 OSTER MD,JOYCE A, 3311 E MURDOCK, 67208
 689-9422
 54 F 1902 80 DR

 OUANO JR MD,BIBIANO B, 1515 S CLIFTON STE 380, 67218
 684-5094
 40 M 74801 79 U

 OWEN MD,LARUE W, 236 N BELMONT, 67208
 19 M 1902 50 OO

 OWEN MD,PERE A, 1128 S CLIFTON, 67218
 681-2108
 37 M 1902 65 ANES

 PAGE MD,RUTH, 1051 N STRATFORD, 67206
 13 F 1902 43 OO

 PALMER MD,DAVID L, PO BOX 9450, 67277
 722-9132
 37 M 1902 64 A

 PARK MD,ROGER WALTER, 3311 E MURDOCK, 67208
 689-9217
 43 M 1902 70 PD

 PARKER MD,HAROLD L, 3311 E MURDOCK, 67208
 689-9107
 32 M 1902 68 FP

 PASSMAN MD,STEVEN M, 835 N HILLSIDE, 67214
 685-4395
 47 M 2803 83 D

 PATTON MD,J MICHAEL, 1431 S BLUFFVIEW STE 210, 67218
 686-2111
 51 M 3005 79 FP

PAXTON MD,EDWARD SCOTT, 3600 E HARRY, 67218
 689-5675
 51 M 2802 83 PATH

 PAY MD,NORMAN T, ST FRANCIS HOSP, 67214
 268-5914
 45 M 74802 77 NR

 PEERY MD,WILLIAM H, UKSM WICHITA, 67214
 261-2650
 46 M 4802 82 IM

 PEIL MD,MICHAEL L, 1035 N EMPORIA #265, 67214
 269-4026
 54 M 1902 81 PM

 PELLETIER JR MD,LAWRENCE L, UKSM WICHITA, 67214
 261-2650
 42 M 3501 71 IM

 PENCE MD,CHARLES D, 3311 E MURDOCK, 67208
 689-9468
 42 M 1902 69 ORS

 PENNER MD,STEVEN D, 855 N HILLSIDE, 67214
 685-1381
 55 M 1902 86 FP

 PENNINGTON MD,KATHERINE, 2113 S BLUFF CT, 67218
 685-5271
 16 F 1902 43 OO

 PETERIE MD,JERRY D, 818 N EMPORIA STE 305, 67214
 264-3505
 48 M 1902 76 IM

 PETERS MD,THOMAS J, 3311 N MURDOCK, 67208
 689-9190
 47 M 2803 79 IM

 PETERSON MD,STACY L, 825 N HILLSIDE, 67214
 688-7500
 55 M 1902 81 PS

 PHIPPS MD,JACK G, 315 N HILLSIDE, 67214
 686-3391
 21 M 1902 53 FP

 PIBURN MD,MARVIN F, 125 N ZELTA, 67206
 263-7455
 22 M 1803 80 GS

 PICKENS MD,ANDREW T, WICHITA PSY PO BOX 8037, 67208
 684-0201
 43 M 2834 69 P

 PINSKER MD,JACOB A, 556 BROADMOOR CT, 67206
 06 M 1902 35 OO

 POLINER MD,LAWRENCE R, 818 N EMPORIA STE 407, 67214
 264-8604
 43 M 3520 83 CD

 POLING MD,TERRY L, 7602 E HARRY, 67207
 682-7411
 36 M 1902 63 FP

 POLLACK MD,SIMON, 7523 PLAZA LANE, 67206
 00 M 79 OO

 POLLOCK MD,ANTHONY G A, 825 N EMPORIA, 67214
 264-2806
 45 M 80305 76 ORS

 POOLE MD,BERNARD T, 825 N EMPORIA, 67214
 264-2806
 37 M 53902 73 ORS

 PORTER MD,GARRY L, 3243 E MURDOCK STE 400, 67208
 686-7351
 35 M 1606 63 P

 POWERS MD,K DEAN, 2703 E CENTRAL, 67214
 683-8386
 23 M 1902 47 GYN

 PRESKORN MD,SHELDON H, UKSM-WICHITA, 67214
 261-2647
 48 M 1902 75 P

 PULLMAN MD,NORMAN K, 3007 E CENTRAL, 67214
 686-7369
 21 M 3006 53 PS

PURINTON MD, LEW W, 1431 S BLUFFVIEW DR STE 209, 67218
685-3030
23 M 1902 48 IM

PUTNAM MD, LYLE B, 4700 W 13TH UNIT 1-1, 67212
11 M 1902 36 OO

RAGHAVAN MD, PARULA P, 2404 GREENLEAF CT, 67226
263-6131
47 F 49501 80 IM

RAGHAVAN MD, PRAKASH V, 1035 N EMPORIA #245, 67214
262-7662
46 M 49501 80 CD

RAMOS MD, MICHAEL, 925 N EMPORIA, 67214
265-2876
55 M 702 82 FP

RANDALL MD, GEORGE R, MID-KANSAS ENT ASSOC, 67211
684-2838
43 M 2802 77 OTO

RANGLES MD, MICHAEL J, 959 N EMPORIA, 67214
265-2924
48 M 1902 75 IM

RAUSA JR MD, FRANCISCO C, 1148 S HILLSIDE, 67211
682-4535
42 M 74808 76 IM

RAWCLIFFE JR MD, ROBERT A, 732 N TOPEKA, 67214
267-1924
29 M 3501 63 ORS

RAZEK MD, HANA A, WESLEY MED CTR 550 N HILLSIDE, 67214
688-2828
47 F 33004 PATH

RAZEK MD, ZACK A, 818 N EMPORIA STE 200, 67214
263-0296
46 M 60501 77 CDTs

READER MD, G WHITNEY, 933 N TOPEKA, 67214
263-5889
48 M 2101 81 CD

REALS MD, WILLIAM J, UKSM WICHITA, 67214
261-2600
20 M 3006 46 PATH

REAZIN MD, WALTER L, 547 TURNBERRY CIR, 67230
685-1381
30 M 1902 59 FP

REDDI MD, RAGHUNATH P, ST JOSEPH MEDICAL CTR, 67218
689-5043
36 M 49521 80 RT

REED MD, A J, 2456 N WOODLAWN, 67220
685-5775
40 M 3901 67 EM

REED MD, D CRAMER, 7520 E 21ST #22, 67226
15 M 2802 46 OO

REED MD, DAVID D, 3333 E CENTRAL STE 214, 67208
685-1291
43 M 1902 70 DR

REED MD, WILLIAM RANDALL, 550 N HILLSIDE, 67214
688-2360
51 M 1611 83 NEO

REISMAN MD, MICHAEL ALAN, 3243 E MURDOCK STE 600, 67208
683-5688
50 M 4804 76 OPH

RELIHAN MD, DONALD A, 655 N WOODLAWN, 67208
684-5158
27 M 1902 54 OPH

REMPER MD, JOHN H, 1515 S CLIFTON STE 240, 67218
685-1812
38 M 3901 70 PS

RHOADS MD, JAMES P, 3311 E MURDOCK, 67208
689-9103
34 M 3520 67 IM

RHODEN MD, CURTIS H, 3243 E MURDOCK STE 500, 67208
684-0252
33 M 1606 67 IM

RHODES MD, IVAN E, 144 S HILLSIDE, 67211
685-9289
25 M 3901 56 R

RHODES MD, LOWELL M, 315 N HILLSIDE, 67214
685-1461
25 M 1902 53 FP

RIEGER MD, ERNEST H, 444 N LORRAINE, 67214
682-4591
29 M 1902 56 GS

RIORDAN MD, HUGH D, 3100 N HILLSIDE, 67219
682-3100
32 M 5605 59 P

ROACH MD, NEIL E, UKSM WICHITA, 67214
261-2647
38 M 1902 68 P

ROAN MD, YEAI, WESLEY MED CTR PERINATAL DIV, 67214
688-2360
41 M 38501 82 PD

ROBERTS D.O., ROGER W, PO BOX 47668, 67201
264-8604
49 M 2879 78 CD

ROBERTS MD, DANIEL K, 3333 E CENTRAL SUITE 301, 67208
688-3185
36 M 3005 71 OBG

ROBERTSON MD, JOSEPH K, 818 N EMPORIA STE 200, 67214
263-0296
41 M 3901 68 GS

ROBINSON MD, G DONALD, 3333 E CENTRAL STE 610, 67208
686-6659
28 M 1902 54 PD

ROBINSON MD, JOHN E, 2708 E CENTRAL, 67214
682-2730
32 M 6201 71 P

ROBINSON MD, ROBERT H, 3311 E MURDOCK, 67208
689-9445
20 M 1902 53 ANES

ROBL MD, DAVID A, 8200 W CENTRAL STE 1, 67212
721-4544
48 M 1902 76 FP

RODRIGUEZ TOCKER MD, LILIA, 1111 N ST FRANCIS, 67214
265-2613
21 F 27501 57 IM

ROMALIS MD, BRIAN E, 3429 E DOUGLAS, 67218
682-5069
39 M 6201 73 P

ROOS MD, MAUREEN, 925 N EMPORIA, 67214
265-2876
53 F 1902 80 FP

ROSE MD, SHELBY D, 3333 E CENTRAL STE 721, 67208
681-2741
40 M 2012 71 PATH

ROSEN MD, DAVID, 818 N EMPORIA #303, 67214
265-3774
48 M 1902 75 PD

ROSENBERG MD, THOMAS F, 2627 E CENTRAL, 67214
684-0501
41 M 1642 72 A

ROSS MD, DENNIS LEE, 1035 N EMPORIA STE 105, 67214
263-7285
47 M 3005 78 NEP

RUSSELL MD, PHILIP W, 3311 E MURDOCK, 67208
689-9351
22 M 1902 44 IM

SABIN JR MD, GEORGE M, 6412 E 9TH, 67206
268-0824
12 M 5002 66 ADM

SADIQ MD, SULEMAN, 1144 N ST FRANCIS, 67214
267-0159
40 M 70401 74 TS

SANCHEZ MD, JOSE J, 3311 E MURDOCK, 67208
689-9287
54 M 1643 87 PD

SANDERS MD, GLORIA D, RIVERSIDE HOSP 2622 W CENTRAL, 67203
945-9161
50 F 1902 PATH

SANTOS MD, JOAQUIN G, 3243 E MURDOCK STE 500, 67208
684-0251
49 M 1902 81 IM

SANTOSCOY MD, GILBERT S, 3311 E MURDOCK, 67208
689-9124
38 M 4812 70 GS

SCANLAN MD, TIMOTHY M, ST JOSEPH MED CTR-ATU, 67218
689-4850
46 M 2604 78 FP

SCHILTZ MD, FRANCES, 115 S RUTAN #10B, 67218
93 F 6701 24 OO

SCHLACHTER MD, ERNEST R, 406 E CENTRAL, 67202
265-0705
24 M 1902 52 FP

SCHLAGECK MD, JOSEPH G, 8200 W CENTRAL, 67212
721-4544
55 M 1902 85 FP

SCHLICHER MD, JOHN E, 3311 E MURDOCK, 67208
689-9346
40 M 1803 72 D

SCHLUETER MD, JOHN J, 144 S HILLSIDE, 67211
685-9289
31 M 3841 62 R

SCHNELLE MD, JOACHIM, 4145 E KELLOGG, 67218
682-6551
44 M 40933 73 FP

SCHOPF MD, CLIFTON C, 222 S RIDGE RD, 67209
945-0142
29 M 1902 57 FP

SCHWARTZ MD, V DEAN, 400 N WOODLAWN #4, 67208
684-3881
24 M 1902 48 FP

SCOTT MD, WILLIAM H, 1431 S BLUFFVIEW STE 111, 67218
685-8262
41 M 4901 73 CD

SEN SARMA MD, PRONAB K, 1144 N ST FRANCIS, 67214
267-0159
45 M 49518 81 CD

SHAFFER MD, PRESTON J, 3788 RUSHWOOD CT, 67226
682-8003
20 M 3005 47 OO

SHAH MD, MUKHTAR H, 3243 E MURDOCK STE 400, 67208
686-7351
40 M 70404 77 P

SHAPIRO MD, WILLIAM M, 818 N EMPORIA STE 201, 67214
263-0348
45 M 1606 84 NS

SHAW MD, RICHARD C, 825 N HILLSIDE, 67214
688-7500
35 M 1902 62 PS

SHELLITO MD, JOHN G, 18 VIA ROMA, 67230
18 M 1606 49 OO

SHELLITO MD, JOHN L, 3311 E MURDOCK, 67208
689-9124
52 M 2407 84 GS

SHIELD MD, CHARLES, 818 N EMPORIA STE 200, 67214
263-0296
46 M 2802 81 GS

SHOFFNER MD, RICHARD W, 3311 E MURDOCK, 67208
689-9271
53 M 3901 82 IM

SHRADER MD, C ERIC, 655 N WOODLAWN, 67208
684-5158
47 M 1902 79 OPH

SHRADER MD, DOYLE A, 12719 BIRCHWOOD DR, 67206
16 M 1902 41 OO

SHURTZ MD, GLEN L, 3333 E CENTRAL STE 214, 67208
685-1291
40 M 4802 81 R

SIFFORD MD, R LAWRENCE, 959 N EMPORIA STE 305, 67214
265-0561
25 M 1803 58 IM

SIMMS MD, DAVID ALAN, 3311 E MURDOCK, 67208
689-9422
50 M 3401 83 DR

SKIBBA MD, RICHARD M, 3311 E MURDOCK, 67208
689-9477
43 M 5606 72 GE

SLUTSKY MD, LAWRENCE JOEL, ST FRANCIS R.M.C., 67214
268-5922
46 M 3501 79 DR

SMITH JR MD, WILLARD J, 851 N HILLSIDE, 67214
685-1371
32 M 1611 65 U

SMITH MD, ALVIN L, 929 N ST FRANCIS, 67214
268-5470
28 M 5606 72 PATH

SMITH MD, LINDALL E, 3333 E CENTRAL STE 408, 67208
682-0411
55 M 1902 PD

SMITH MD, TIMOTHY WM, 1035 N EMPORIA STE 265, 67214
269-4026
49 M 1902 76 IM

SNYDER MD, GREGG M, 902 N HILLSIDE, 67214
687-1441
27 M 1803 66 NS

SOLOMON MD, HERMAN, 835 N HILLSIDE, 67214
685-4395
37 M 2701 69 D

SOLTZ MD, ROBERT A, 3311 E MURDOCK, 67208
689-9381
47 M 2803 77 PD

SOMERS MD, MARVIN M, 2506 BENJAMIN, 67204
23 M 1902 48 OO

SPANN MD, RICHARD W, 3243 E MURDOCK STE 500, 67208
684-0252
40 M 1902 66 PUD

STAMBAUGH MD, ROY A, 2456 N WOODLAWN, 67220
685-5691
34 M 2501 85 EM

STAMPS MD, PHIL, 3600 E HARRY, 67218
689-5668
37 M 3901 PATH

STARK MD, JAMES R, 719 BROOKFIELD RD, 67206
689-9422
20 M 1902 44 OO

STECKLEY MD, RICHARD ALLEN, PO BOX 47669, 67201
265-1308
49 M 2105 80 IM

STEELBERG MD, ELSIE, 337 N WACO, 67202
265-8872
34 F 1606 84 P

STEIN MD, PAUL S, 3243 E MURDOCK STE 601, 67208
685-2377
40 M 3305 73 NS

STEMBRIDGE MD, TRAVIS W, 3333 E CENTRAL STE 301, 67208
685-7234
47 M 4802 78 OBG

STREET MD, DAVID E, 818 N EMPORIA STE 200, 67214
263-0296
35 M 2101 67 GS

STREIT MD, JEROME G, 1131 S CLIFTON, 67218
689-5500
48 M 1902 78 FP

SUERO MD, JESUS T, 1148 S HILLSIDE, 67211
681-3371
33 M 74802 57 PUD

SULLIVAN MD,LEONARD L, 3311 E MURDOCK, 67208 689-9454 35 M 1902 62 PD	TRUDEAU MD,DAVID L, ST JOSEPH MED CTR ATU, 67218 689-4853 40 M 2604 78 ADT
SVOBODA MD,LOIS V, 818 CARRIAGE PKWY, 67208 685-8231 39 F 1602 81 FP	TRUJILLO MD,ANTERO A, 1431 S BLUFFVIEW STE 117, 67218 685-6466 36 M 73701 81 ANES
SVOBODA MD,WILLIAM B, 1035 N EMPORIA #270, 67214 685-2377 36 M 1602 81 PDN	UHLIG MD,PAUL J, 3311 E MURDOCK, 67208 689-9191 28 M 1902 57 PD
SWEET MD,DONNA E, UKSM WICHITA, 67214 261-2650 48 F 1902 80 IM	VAL-MEJIAS MD,JESUS E, 818 N EMPORIA STE 407, 67214 264-8604 45 M 23101 84 CD
TATPATI MD,DANIEL A, 1144 N ST FRANCIS, 67214 267-0159 44 M 49535 78 TS	VAN LEEUWEN MD,GERARD J, UKSM WICHITA, 67214 261-2631 29 M 1803 80 NEO
TATPATI MD,OLGA ADELINA, 1515 S CLIFTON STE 250, 67218 687-3100 44 F 49535 78 PD	VARENHORST MD, MICHAEL P, 530 N LORAIN, 67214 683-5611 52 M 1803 85 OPH
TAYLOR MD,STEVEN L, 3311 E MURDOCK, 67208 689-9422 46 M 1902 78 R	VAUGHAN MD,D ANN, UKSM-W DEPT OF PSYCHIATRY, 67214 261-2647 45 F 1902 75 P
TERREBONNE MD,MAE E, 3311 E MURDOCK, 67208 689-9409 49 F 2105 87 PD	VINE MD,DONALD LEE, 3311 E MURDOCK, 67208 689-9240 39 M 511 79 CD
THELEN MD,J CHRISTINE, 1738 N ROOSEVELT, 67208 13 F 5104 50 OO	VINZANT MD,WHITNEY L, 1515 S CLIFTON STE 270, 67218 686-1991 45 M 1902 74 GS
THOMPSON MD,DANIEL M, PO BOX 4069, 67204 838-3381 19 M 1902 50 FP	VOTH MD,DOUGLAS W, UKSM WICHITA, 67214 261-2650 34 M 1902 61 IM
THOMPSON MD,WILLIAM E, MUNGER STATION PO BOX 8253, 67208 683-4032 30 M 3005 60 OPH	WADE MD,EDWARD J, 1036 LAWRENCE CT, 67206 686-6835 53 M 1902 83 ANES
TIHEN MD,EDWARD N, 1227 N RIVER BLVD, 67203 24 M 1606 55 OO	WADUD MD,ABDUL, 1543 S HILLSIDE, 67211 682-6814 35 M 70409 74 P
TILLER MD,GEORGE R, 5101 E KELLOGG, 67218 684-5255 41 M 1902 68 AM	WALKER D.O., MARSHALL D, 1301 N WEST ST, 67203 945-5245 41 M 2878 80 OTO
TILTON MD,FRANK M, 3311 E MURDOCK, 67208 689-9137 33 M 2002 68 N	WALLING MD,ADRIAN E, 2319 GREENLEAF, 67226 689-5500 47 M 80302 78 FP
TINTEROW MD,MAURICE M, WICHITA ST U CAMPUS BOX 43, 67208 17 M 4802 46 OO	WALLING MD,ANNE D, UKSM WICHITA, 67214 261-2607 47 F 80302 PH
TIPPIN JR MD,ERNEST E, 959 N EMPORIA, 67214 265-5256 24 M 1902 50 OTO	WARD MD,LARRY G, 818 N EMPORIA STE 307, 67214 264-9476 54 M 1902 82 ANES
TOCKER MD,ALFRED M, 1111 N ST FRANICS, 67214 265-2613 15 M 4802 53 OO	WARREN JR MD,JOHN W, 63 VIA VERDE, 67230 15 M 2501 49 OO
TONN MD,GERHART R, 855 N HILLSIDE, 67214 685-1381 16 M 1902 44 OO	WARREN MD,LLOYD P, 1202 WILLOW LN, 67208 683-7223 11 M 1902 36 OO
TOOHEY MD,JOHN S, 3311 E MURDOCK, 67208 689-9175 50 M 5605 82 ORS	WARREN MD,WIRT A, 526 S BLUFF, 67218 267-0520 09 M 2802 36 PGER
TOSH MD,FRED E, 1900 E NINTH, 67214 268-8391 30 M 4706 80 PH	WEAVER MD,J ROBERT, 641 N WOODLAWN #66, 67208 265-5731 21 M 1902 48 OO
TRACY MD,TERRY A, 3333 E CENTRAL STE 301, 67208 685-7234 35 M 2803 68 OBG	WEAVER MD,JACK D, 959 N EMPORIA, 67214 265-7241 16 M 2802 46 OO
TRAVERS MD,HENRY, WESLEY MED CTR 550 N HILLSIDE, 67214 688-2812 46 M 4114 79 PATH	WEBER JR MD,HUGO P, 1035 N EMPORIA STE 105, 67214 263-7285 40 M 702 73 IM
TRETBAR MD,HARVEY A, 3243 E MURDOCK #500, 67208 684-0251 25 M 1902 52 IM	WEBSTER MD,BOBBY W, 2212 E CENTRAL, 67214 265-0959 48 M 4802 75 OBG
TREWEEKE MD,MICHAEL W, 2916 E CENTRAL, 67214 684-5243 46 M 1902 73 IM	WEIPPERT MD,EDWARD J, 8200 W CENTRAL #1, 67212 721-4454 44 M 1902 71 FP

WELCH MD,LAUREN K, 3243 E MURDOCK STE 601, 67208
685-2377
35 M 1902 62 N

WELLS MD,MAX MICHAEL, 3311 E MURDOCK, 67208
688-2820
50 M 1902 79 PATH

WELLSHEAR MD,CHARLES C, WICHITA PSY CTR PO BOX 8037, 67208
684-0201
30 M 4706 62 P

WENINGER MD,JOHN H, 1148 S HILLSIDE STE 12, 67211
682-6523
32 M 3005 63 FP

WEST MD,WILLIAM T, 3311 E MURDOCK, 67208
689-9234
24 M 1902 49 OBG

WHEELER MD,NICKY RAY, 1515 S CLIFTON STE 390, 67218
684-0220
48 M 1902 74 PS

WHEELER MD,PINCKNEY R, 2208 W 13TH, 67203
943-2118
18 M 3901 57 FP

WHITAKER MD,JAMES A, 3243 E MURDOCK STE 500, 67208
684-0251
44 M 1902 74 IM

WHITE MD,CHARLES F, 3600 E HARRY, 67218
689-4797
38 M 1611 PM

WHITE MD,CHARLES M, 18 VIA VERDE, 67230
15 M 3005 48 OO

WHITE MD,KERMIT E, 2525 E CENTRAL, 67214
682-6607
50 M 4707 84 P

WHITESIDE MD,WILLIAM H, ST JOSEPH MED CTR 3600 E HARRY, 67218
689-6216
46 M 53903 84 PD

WILDER MD,LOWELL W, 655 N WOODLAWN, 67208
684-5158
35 M 4109 67 OPH

WILKINSON MD,LARRY K, 1520 S CLIFTON, 67218
685-2371
46 M 1902 75 FP

WILLIAMS MD,CHARLES L, 3311 E MURDOCK, 67208
689-9168
16 M 2834 50 OO

WINN MD,TERRIA L, 959 N EMPORIA, 67214
265-7241
56 F 1902 83 OPH

WISNER JR MD,HARRY J, 3311 E MURDOCK, 67208
689-9169
17 M 3005 47 IM

WITTMANN MD,ALBERT F, 2323 N WOODLAWN APT 211, 67220
10 M 2834 40 OO

WOLF MD,PATRICK G, 8420 TURON LN, 67207
685-3030
52 M 1902 78 IM

WOLFE MD,FREDERICK, 1035 N EMPORIA #230, 67214
263-2125
36 M 3508 69 RHU

WOOD MD,GARY B, 8527 BOXTHORN, 67226
21 M 2802 51 OO

WOOD MD,ROBERT D, 1441 N ROCK RD STE 1001, 67206
486-2127
26 M 1902 53 FP

WOODHOUSE MD,CHARLES L, 347 N BROADVIEW, 67208
265-8821
10 M 1902 34 OO

WOODRING MD,CATHY S, 222 S RIDGE RD, 67209
945-0142
51 F 3546 82 FP

WORSING JR MD,ROBERT A, 3311 E MURDOCK, 67208
689-9231
47 M 2604 81 ORS

WRAY JR MD,REGINALD P, PO BOX 781653, 67278
685-4389
40 M 4113 84 ANES

WRAY MD,ALEXANDER J, 120 E 21ST ST, 67214
838-4912
19 M 1902 49 FP

WYATT-HARRIS MD,PATRICIA G, 345 N HILLSIDE, 67214
683-6766
55 F 1902 82 OBG

YOON MD,CHANG SUP, BOX 782438, 67278
685-4389
46 M 58303 81 ANES

YOUNG MD,DOUGLAS L, 3311 E MURDOCK, 67208
689-9213
42 M 1902 72 IM

YOUNGBERG MD,DEAN I, 959 N EMPORIA #201, 67214
684-5243
00 M 1902 73 IM

ZARNOW MD,HILARY, ST FRANCIS REG MED CTR, 67214
268-5909
45 M 1611 74 R

ZATZKIN MD,JAY B, 818 N EMPORIA STE 403, 67214
262-4467
46 M 2002 79 IM

ZEPICK MD,LYLE F, 3311 E MURDOCK, 67208
263-5889
50 M 6001 81 CD

ZIEGLER MD, JUDY P, 3311 E MURDOCK, 67208
689-9414
54 F 1803 84 PD

ZIEGLER MD,JOHN M, 3311 E MURDOCK, 67208
689-9195
55 M 1720 85 PD

ZIELKE MD,STEVEN L, 3333 E CENTRAL STE 504, 67208
685-2223
53 M 1643 86 OBG

ZIMMERMAN MD,KENNETH D, 934 CRESTLINE, 67212
526-3925
29 M 3901 58 OM

ZONGKER MD,PHILIP E, 3311 E MURDOCK, 67208
689-9422
43 M 1902 71 R

WINCHESTER — 913 (Shawnee County Medical Society)

HUSTON MD,FRANCIS W, DRAWER H, 66097
06 M 1601 34 FP

WINFIELD — 316 (Cowley County Medical Society)

CARRO MD,F AURELIO, PO BOX 38, 67156
23 M 27501 67 OO

KAUFMAN MD,LELAND R, 221 WEST 8TH, 67156
221-3350
33 M 1902 61 FP

MAC KILLOP JR MD,DANIEL, 4 FLEETWOOD DR, 67156
11 M 2407 62 OO

MILLER MD,FRANKLIN R, 301 PARK, 67156
02 M 2401 54 OO

PIZARRO MD, FE E, 1317 WHEAT RD PO BOX 544, 67156

221-3200
44 F 74810 81 PD

PRICE MD, PETER G, PO BOX 544, 67156

221-3200
26 M 64901 57 GS

SAMUEL MD, CHANDY C, 1211 E FIFTH, 67156

221-6100
35 M 49527 76 GS

SHAH MD, ASHOK H, 1317 WHEAT RD PO BOX 544, 67156

221-3200
41 M 49548 87 OBG

SHIPPEY MD, DEAN U, 1302 E 5TH, 67156

221-2300
49 M 64914 85 R

WHITE MD, R BURNLEY, 117 W 9TH, 67156

221-2950
24 M 1902 52 FP

WILCOX EXEC SEC, GENE M., COWLEY CO MEDICAL SOC, 67156

221-2267
00 M

WINBLAD MD, J KENT, 15 FLEETWOOD, 67156

221-6100
51 M 1902 74 OBG

WINBLAD MD, JAMES N, 1211 E 5TH ST, 67156

221-6100
27 M 1902 53 GS

WINBLAD MD, JOHN M, 1211 E FIFTH, 67156

221-6100
55 M 1902 82 FP

YATES CENTER — 316
(Allen County Medical Society)

ATKIN MD, J D, 1004 E MADISON, 66783

625-2312
35 M 3901 63 GP



IS YOUR LISTING ACCURATE?

If there is an error in your listing, please notify the Executive Office so we can correct our records.

Send corrections to:

Ramona Perez
Membership Secretary
The Kansas Medical Society
1300 Topeka Avenue
Topeka, KS 66612

Resident Physician Section

ARAFILES MD, ESTHER D N, RR 2, OSKALOOSA, 66066
ARPIN MD, JEFFREY P, MUNSON ARMY HOSP, LEAVENWORTH, 66027
ASHBURN MD, WILLIAM T, 1131 S CLIFTON, WICHITA, 67218
AZIZ MD, SAIF A, 6602 E HARRY #904, WICHITA, 67207
BABER MD, JAMES W, 929 N ST FRANCIS ANES DEPT, WICHITA, 67214
BALDWIN MD, THOMAS F, 39TH & RAINBOW, KANSAS CITY, 66103
BARCELO MD, JEANNE A, 857 PORTER, WICHITA, 67203
BARKER, MONTY R, 8130 W 54TH TERR, SHAWNEE MISSION, 66202
BARR, ROBIN R, 6659 OUTLOOK, SHAWNEE MISSION, 66202
BERGH MD, JORGE H., 1001 N MINNEAPOLIS, WICHITA, 67214
BECK MD, WILLIAM R, 4451 FRANCIS, KANSAS CITY, 66103
BECKER MD, NANCY J, 4107 FRANCIS, KANSAS CITY, 66103
BENNING, TIMOTHY C, 1915 HOMESTEAD, WICHITA, 67208
BERGH MD, JAMES R, UKSM - WICHITA 1010 N KANSAS, WICHITA, 67214
BERNHARDT MD, MARK, 6743 PEPPERWOOD CT, WICHITA, 67226
BHARATI MD, RALPH, 1010 N KANSAS PSY DEPT, WICHITA, 67214
BIEGERT MD, DOUGLAS, 550 N HILLSIDE, WICHITA, 67214
BLACK MD, BRADFORD T, KU MEDICAL CENTER, KANSAS CITY, 66103
BOCK, PETER A, 205 PRATHER, MULVANE, 67110
BOOTON MD, DEBBIE S, 150 N RIDGEWOOD, WICHITA, 67208
BRANIECKI MD, MARLYLEE A, 4130 EATON, KANSAS CITY, 66103
BRENNER MD, BRIAN C, 929 N ST FRANCIS, WICHITA, 67213
BRIDGE MD, ROBERT S, 39TH & RAINBOW OTO DEPT, KANSAS CITY, 66103
BULLER MD, DAVID L, 711 S CLIFTON, WICHITA, 67218
BURKE MD, MICHAEL A, KU MEDICAL CENTER, KANSAS CITY, 66103
CAMPBELL MD, LINDA HINSCH, 6520 WALNER, SHAWNEE MISSION, 66202
CANDELA, M.D., ANDRES, 550 N HILLSIDE, WICHITA, 67214
CANNADAY MD, JOHN J, 550 N HILLSIDE, WICHITA, 67214
CARLSON MD, MARK V, 3243 E MURDOCK STE 303, WICHITA, 67208
CERVENY MD, CARLA J, 39TH & RAINBOW, KANSAS CITY, 66103
CHENG, MEI Y, 6915 CROYDEN CIRCLE, WICHITA, 67226
CDCHRAN III DO, CASEY G, 925 N EMPORIA, WICHITA, 67214
COCHRAN MD, KEVIN S, 4605 BELL, KANSAS CITY, 64112
COHN MD, ELLIOT J, KU MED CENTER, KANSAS CITY, 66103
CONGRESS MD, HOWARD J, 44TH & WORNALL, KANSAS CITY, 64111
COOK MD, ANDREW S, 550 N HILLSIDE OBG DEPT, WICHITA, 67214
COUGHENOUR MD, MARK E, 8781 GODDARD, SHAWNEE MISSION, 66214
COWLEY JR MD, BENJAMIN D, 4125 THOMPSON NO 12, KANSAS CITY, 66103
CRESWELL MD, VALERIE A, 1137 N ROOSEVELT, WICHITA, 67208
CUTLER MD, PAUL R, 2301 HOLMES, KANSAS CITY, 64108
DANSILL MD, DAVID J, 7677 E 21ST #2110, WICHITA, 67206
DEDON MD, JON F, 9307 OUTLOOK, SHAWNEE MISSION, 66207
DEGNER MD, JAMES C, 4901 ARLENE, WICHITA, 67220
DELGADO MD, SERGIO VICTOR, PO BOX 829, TOPEKA, 66601
DENNING MD, DALE P, 714 N YALE, WICHITA, 67208
DETURK MD, DWAYNE L, 550 N HILLSIDE, WICHITA, 67214
DOOLITTLE MD, GARY C, KU MED CENTER, KANSAS CITY, 66103
DOOLITTLE MD, GARY C, 929 N ST FRANCIS, WICHITA, 67214
DOUBEK, DEBBIE L, 4608 W 62ND, SHAWNEE MISSION, 66205
DOWNS MD, NANCY J, 12603 GRANADA, SHAWNEE MISSION, 66209
DREES MD, BETTY M, 9227 MASTIN, SHAWNEE MISSION, 66212
EARL DO, JEFFREY J, KU MED CENTER, KANSAS CITY, 66103
EISEMANN MD, ALLAN D, 3243 W 43RD, KANSAS CITY, 66103
ERND BORMO MD, SAMIR, 3119 106 RANDOLPH, TOPEKA, 66611
ERNST MD, R L, 803 FRANKLIN, WICHITA, 67203
EUGENIO MD, HENRY M, 216 E 4TH, CHERRYVALE, 67335
FARAG MD, AZMI E, 940 N TYLER, WICHITA, 67212
FREDRICKSON MD, DOREN D, BOX 975 KUMC, KANSAS CITY, 66103
FUGATE MD, CARL L, 612 N CHESTNUT, BELOIT, 67420
GERWICK MD, CHARLES L, KU MEDICAL CENTER, KANSAS CITY, 66103
GODFREY MD, JOSEPH L, 2700 SW 6TH, TOPEKA, 66606
GOERING MD, MARK, 550 N HILLSIDE, WICHITA, 67214
GOODWIN MD, JOHN A, 6500 W 78TH TERR, SHAWNEE MISSION, 66204
GRABAU MD, GUY M, 928 N RUTAN, WICHITA, 67208
GRANT MD, MICHAEL E, 1221 EASTMOOR, WICHITA, 67207
GWINN MD, DOUGLAS R, 1508 E 151ST TERR, OLATHE, 66062
HALL MD, MARK S, 1131 S CLIFTON, WICHITA, 67218
HAM, ROBERT E, 921 N BATTIN, WICHITA, 67208
HAMILL, JOHN M, 4029 SPRINGFIELD, KANSAS CITY, 66103
HARMON MD, GARY S, 6830 W 52ND, SHAWNEE MISSION, 66202
HARPER, DIANE M, 4412 W 94TH, SHAWNEE MISSION, 66207
HEADRICK MD, DANIEL E, 3200 N PRAIRIE HILLS DR, HUTCHINSON, 67501
HENDRICKS, WILLIAM J, 9739 W 85TH, SHAWNEE MISSION, 66212
HERL MD, CARY J, 737 FAIRDALE #2E, SALINA, 67402
HERRON, KRISTINE G, 8549 WEDD, SHAWNEE MISSION, 66212
HO MD, SAMUEL Y, 44TH & WORNALL RD, KANSAS CITY, 64111
HOHLY MD, EVE K, 3923 HARRISON, KANSAS CITY, 64110
HOLLAND JR MD, DAVID L, 138 N LORRAINE, WICHITA, 67214
HORNBAKER MD, STANLEY D, 211 E MAIN PO BOX 309, CARBONDALE, 66414
HOUCK MD, CONSTANCE S, KU MED CENTER DEPT OF PD, KANSAS CITY, 66103
HUND MD, MORRIS A, 736 CHICKADEE, WICHITA, 67212
HUTCHINSON MD, STEVEN A, 4128 E ENGLISH, WICHITA, 67218
HUTSEY MD, PAUL J, 3430 EDGE MONT, WICHITA, 67208
JACKSON MD, THOMAS M, 5308 E THIRD, WICHITA, 67208
JANKOWSKI MD, KAZIMIERZ W, TOPEKA ST HOSP SG & K I, TOPEKA, 66606
JASTER MD, PAUL JOSEPH, 3243 E MURDOCK SUITE 303, WICHITA, 67208
JOHNSON MD, TERESA F, 18 RENFREW, WINFIELD, 67156
KEITH MD, REX B., 925 N. EMPORIA, WICHITA, 67214
KENNING MD, GERALD F, 17 BEECHWOOD LN, HUTCHINSON, 67502
KERLEY MD, SPENCER W, 4726 W 78TH TERR, SHAWNEE MISSION, 66208
KETCHERSIDE JR MD, WILLIAM J, 2929 BALTIMORE STE 425, KANSAS CITY, 64108
KIRKPATRICK DO JON P, 2716 W CENTRAL, WICHITA, 67203
KIRWAN MD, LAURENCE A, 4177 BROADWAY, KANSAS CITY, 64111
KLEIN MD, TERRY D, 925 N EMPORIA, WICHITA, 67214

KNATZ MD, JO M, 4745 CANTERBURY, SHAWNEE MISSION, 66205
KOWALSKI MD, PETER C, 1351 SW CAMPBELL, TOPEKA, 66604
KOWALSKI MD, STEPHEN F, 1417 SW MACVICAR, TOPEKA, 66604
LANG MD, GORDON, 323 RUSSELL, WAKEENEY, 67672
LAWHORN MD, CHARLTON D, 2739 S 45TH TERR, KANSAS CITY, 66106
LAWHORN MD, STEPHANIE LU, 2739 S 45TH TERR, KANSAS CITY, 66106
LEIS MD, EDWARD A, 2457 BONN, WICHITA, 67217
LUNBERRY MD, JULIA J, 7627 E 37TH N STE 3210, WICHITA, 67226
LYRENE MD, STEPHEN A, MENNINGER PD BOX 829, TOPEKA, 66601
MADDOX MD, OWEN, 550 N HILLSIDE, WICHITA, 67214
MADER MD, ELAINE M, 823 S WATSON, WICHITA, 67207
MALONE MD, DAVID G, 4801 FAIRMONT, KANSAS CITY, 64112
MARPLES MD, BRADLEY W, 901 GARFIELD, TOPEKA, 66606
MARSHALL, ROGER W, 2200 S ROCK RD #1517, WICHITA, 67207
MARTIN MD, JUAN E, 1232 BELL HOSP, KANSAS CITY, 66103
MARTINSON MD, EDWARD E, UKMC - REHAB MED DEPT, KANSAS CITY, 66103
MCCOWEN, HERBERT M, 4835 W 62ND TERR, SHAWNEE MISSION, 66205
MCDONALD MD, THOMAS L, KUMC 39TH & RAINBOW, KANSAS CITY, 66103
MCKITTRICK MD, RICHARD, 5544 CHADWICK, SHAWNEE MISSION, 66205
MCMEERIN MD, SHEILA P, 7713 ABERDEEN RD, SHAWNEE MISSION, 66208
MILBURN JR MD, MERLE E, 500 EISENHOWER RD, LEAVENWORTH, 66048
MILLS MD, MELISSA J, 2929 BALTIMORE STE 435, KANSAS CITY, 64108
MOHR MD, SANDRA N, 1010 N KANSAS, WICHITA, 67214
MURPHY MD, JOHN P, KU MED CENTER, KANSAS CITY, 66103
MURROW MD, R W, 5556 SANTA FE, SHAWNEE MISSION, 66202
NEEF MD, DOUG STEVENS, 1010 N KANSAS, WICHITA, 67214
NEIS MD, PAUL R, KUMC 39TH & RAINBOW, KANSAS CITY, 66103
NELSON MD, DOUGLAS LEROY, 4210 W 68TH TERR, SHAWNEE MISSION, 66208
NIEMAN MD, JOHN L, 9801 JUNIPER LANE, SHAWNEE MISSION, 66207
NOORDHOEK MD, LYLE J, KU MEDICAL CENTER, KANSAS CITY, 66103
OLIVE JR, MD, ROBERT J, 249 N BATTIN, WICHITA, 67208
PALAGANAS-TOSCO MD, AMANDA C, MCLDUTH MED CL, MCCLOUTH, 66054
PENZLER MD, CINDY E, 5229 W 57TH TERR, SHAWNEE MISSION, 66205
PETERSEN MD, LAURA J, 2311 MARTY APT 5, KANSAS CITY, 66103
POLASEK MD, CARLA L, PO BOX 829, TOPEKA, 66601
PRESTON MD, KEVIN L, 3511 WOODS CT, MANHATTAN, 66502
PROCHASKA MD, MARK L, 5316 SW TENTH #301, TOPEKA, 66604
RANNEY MD, BONNIE M, 3243 E MURDOCK STE 303, WICHITA, 67208
REALS MD, THOMAS C, 1010 N KANSAS, WICHITA, 67208
REDMON DO, MARY L, KU MED CENTER, KANSAS CITY, 66103
REED MD, KENNETH L, KU MED CENTER ANES DEPT, KANSAS CITY, 66103
REGIER MD, DONALD D, 925 N EMPORIA, WICHITA, 67214
REINSEL MD, MARK S, K U MED CENTER, KANSAS CITY, 66103
REINTJES MD, STEPHEN L, 2901 W 73RD, SHAWNEE MISSION, 66208
REUSSER, LAYNE M, 3425 E ENGLISH STE 303, WICHITA, 67218
RHOADS MD, ANNE C, 3804 BOOTH #5, KANSAS CITY, 66103
RHOADS MD, JEFFREY P, 901 GARFIELD, TOPEKA, 66606
RIDDEL MD, STEPHEN JAMES, 1424 WESTFIELD, WICHITA, 67212
ROBISON MD, DAVID E, UKMC 39TH & RAINBOW, KANSAS CITY, 66103
ROGERS MD, ANDREW L, 5626 PARK HOLLOW, WICHITA, 67208
RUNDQUIST MD, BETH E, KU MED CENTER, KANSAS CITY, 66103
RUSSELL MD, BRIAN K, 2200 W 48TH TERR, SHAWNEE MISSION, 66205
SACHEN MD, FREDERICK L, 4201 WEST 90TH, SHAWNEE MISSION, 66207
SCANLON MD, EDWARD K, UKMC 39TH & RAINBOW, KANSAS CITY, 66103
SCHACK MD, STANLEY H, KUMC 39TH & RAINBOW, KANSAS CITY, 66103
SCHERMOLY MD, MARTIN J, 1737 W 35TH, KANSAS CITY, 64111
SEGRETO DO, MARY C, BOX 829, TOPEKA, 66601
SHERARD, JOHN L, 1910 FEDERAL, KANSAS CITY, 66103
SHERARD, SARAH L, 1910 FEDERAL, KANSAS CITY, 66103
SHUTT MD, CHARLES B, 409 SIERRA DR, LAWRENCE, 66044
SIEGLE MD, LORA A, 1131 S CLIFTON, WICHITA, 67218
SIMPSON MD, KAREN M, KU MED CENTER, KANSAS CITY, 66103
SIMS MD, PETER MORRIS, PO BOX 829, TOPEKA, 66601
SITZMAN JR MD, EVERETTE, KU MED CTR PSY DEPT, KANSAS CITY, 66103
SKOCH MD, MICHAEL G, 2310 WHITE OAK DR, WICHITA, 67207
SPERRY MD, ROBERT E, KUMC 39TH & RAINBOW, KANSAS CITY, 66103
SPITTLER MD, LEO J, 12409 SAYAMDR, SHAWNEE MISSION, 66209
SPRATT MD, DENNIS P, 1131 S CLIFTON, WICHITA, 67218
STANLEY MD, DANIEL S, 608 N PERSHING, WICHITA, 67208
STASS-ISERN MD, MERRILL, 1405 W 50TH TERR, KANSAS CITY, 64112
STEPHENS DO, GORDON M, 1010 N KANSAS, WICHITA, 67214
STEVENS MD, WM. MICHAEL, 3311 E MURDOCK, WICHITA, 67208
STILES MD, MICHAEL C, 4730 LIBERTY, KANSAS CITY, 64112
SWARTZ, MARSHA A, 1840 S LAUREL, WICHITA, 67207
TABOR MD, REGAN W, 438 N EDMORE, WICHITA, 67208
TICKLES MD, DEBRA F, KU MED CENTER PED DEPT, KANSAS CITY, 66103
TREGO MD, ANDREW J, 210 N SOCORA, WICHITA, 67212
UTERMAN MD, STEVEN R, KU MEDICAL CENTER, KANSAS CITY, 66103
WATANABE, MASAYO, CHILDREN'S MERCY HOSP, KANSAS CITY, 64108
WATSON MD, RICHARD L, 722 S VASSAR, WICHITA, 67218
WATTS MD, GARRETT E, 249 N BATTIN, WICHITA, 67208
WEBER MD, ALICE, 1718 E WATERMAN #2, WICHITA, 67211
WEGNER MD, MARY M, PO BOX 829, TOPEKA, 66601
WEINSTEIN, GARY L, 5007 LAMAR STE 5, SHAWNEE MISSION, 66202
WELCH MD, KATHRYN E, 700 S BROADWAY, LEAVENWORTH, 66048
WILLIAMS MD, RONALD P, 158 N NEVADA, WICHITA, 67212
WILSON MD, J WELLS, 550 N HILLSIDE, WICHITA, 67214
WONG MD, CURTIS S F, 929 N ST FRANCIS, WICHITA, 67214
WONG MD, GEORGE F, 39TH & RAINBOW, KANSAS CITY, 66103
WOODS MD, GREGORY A, 5300 W 49TH, SHAWNEE MISSION, 66205
WOODS, DENNIS D, 7942 BOOTH, SHAWNEE MISSION, 66208
YANG MD, GAN-HSIUNG, 3101 - H RANDOLPH, TOPEKA, 66611
ZOELLNER MD, TIMOTHY M, KU MEDICAL CENTER, KANSAS CITY, 66103



Medical Student Section

ADAMS,MARY E, 3828 BOOTH #10, KANSAS CITY, 66103
ADKISSON,WAYNE O, 4323 CAMBRIDGE, KANSAS CITY, 66103
AGIAR,MARY C, 948 W 33RD TERR, KANSAS CITY, 64111
AHNEMANN,JANET L, 4464 FISHER, KANSAS CITY, 66103
ALDERMAN,LILLIAN C, 1928 W 36TH, KANSAS CITY, 66103
ALIFANO,CONNIE L, 4323 CAMBRIDGE, KANSAS CITY, 66103
ALLEY,ROBYN R, 4318 ADAMS, KANSAS CITY, 66103
ANTHONY,THOMAS, 3600 RAINBOW #117, KANSAS CITY, 66103
ARNOLD,KATHLEEN J, 6510 E 29TH N #702, WICHITA, 67226
ASH,LISA M, 8009 BELLVIEW, KANSAS CITY, 64114
ATKINS,JEFFREY A, 6648 CHARLES, SHAWNEE MISSION, 66216
BAILEY,MICHAEL J, RT 2, HALSTEAD, 67056
BAKEBERG,KATHY D, 3838 RAINBOW #407, KANSAS CITY, 66103
BAKER,JAMES R, 9108 SUMMIT, SHAWNEE MISSION, 66215
BAKER,MICHAEL P, 3838 RAINBOW #808, KANSAS CITY, 66103
BANKS,DONALD E, 3741 SPRINGFIELD, KANSAS CITY, 66103
BARE,JANE E, 3747 SPRINGFIELD, KANSAS CITY, 66103
BARNES,EDWARD L, 3749 EATON, KANSAS CITY, 66103
BASHAM,BRIAN E, 456 COURTELEIGH DR, WICHITA, 67218
BASINGER,BRADLEY B, 6747 PAR LN #1410, WICHITA, 67212
BAUER,JOSEPH G, 9640 CATALINA, SHAWNEE MISSION, 66207
BAUER,LAIRD A, 4171 CAMBRIDGE, KANSAS CITY, 66103
BEARCE,SHARON K, 7677 E 21ST #1402, WICHITA, 67206
BECK JR,CALVIN E, 808 W 99TH, KANSAS CITY, 64114
BECKER,BRYAN N, 6501 WENONGA, SHAWNEE MISSION, 66208
BEILMAN,GREG J, 625 EMERSON, WICHITA, 67212
BELDEN,MARY J, 5010-12 GLENWOOD, SHAWNEE MISSION, 66202
BELL,GREGORY A, 3622 W 74TH, KANSAS CITY, 66208
BELZ,MICHAEL K, 14909 W 82ND TERR, SHAWNEE MISSION, 66215
BENNETT,S H, 3630 BELL 3RD FL, KANSAS CITY, 64111
BERRIDGE,DEBRA L, 2907 W 43RD, KANSAS CITY, 66103
BETTIN,BRYCE D, 1820 S 31ST, KANSAS CITY, 66106
BETTY,JANE M, 4312 ADAMS, KANSAS CITY, 66103
BIBERSTEIN,GREG A, 1739 LEXINGTON, WICHITA, 67218
BLACK,DAVID L, 4448 FISHER, KANSAS CITY, 66103
BLACKBURN,TIMOTHY L, 2831 MCALISTER, TOPEKA, 66614
BLAKELEY,SHARON L, 1004 WILLOW, OTTAWA, 66067
BLAKELY,KENT W, 5400 E 21ST #617, WICHITA, 67208
BLOMQUIST,GLENDA L H, 2707 N 72 TERR, KANSAS CITY, 66109
BLUME, GREGORY M, 1532 NOTTINGHAM, WICHITA, 67204
BOGNER,KENT A, 4144 BOOTH PL APT #7, KANSAS CITY, 66103
BOLING,JAMES M, 7500 BRIAR, SHAWNEE MISSION, 66208
BOLTON,MARK E, 935 S LEXINGTON, WICHITA, 67218
BORRA,HENRY M, 3921 BOOTH APT #1, KANSAS CITY, 66103
BOTTERON,GREGORY W, 4731 WYOMING, KANSAS CITY, 64112
BOTTERON,KELLY N, 4731 WYOMING, KANSAS CITY, 64112
BOYD,HAROLD D, 5015 ELMWOOD, KANSAS CITY, 66106
BRANDT,MERRILEE R, 4145 ADAMS, KANSAS CITY, 66103
BRAND,STEVEN D, 1717 S 31ST APT B, KANSAS CITY, 66106
BRENT,CHRISTOPHER R, 2418 VICTORIA DR #7302, KANSAS CITY, 66106
BRINKMAN, MARK F, 427 CAMBRIDGE, KANSAS CITY, 66103
BROOKS,DOUGLAS G, 6313 W 50TH, SHAWNEE MISSION, 66202
BROWN,JEFFERY C, 7401 SCHOOL, WICHITA, 67212
BROWN,LORAIN E, 915 N CRESTWAY, WICHITA, 67208
BROWN,MICHELLE R, 411 N GROVE, WICHITA, 67214
BROWN,SPENCER A, 3828 BOOTH APT 3, KANSAS CITY, 66103
BRUEGGER,DANIEL E, 8205 W 56TH TERR, SHAWNEE MISSION, 66202
BUCK JR,WILLIAM D, 7612 N 79 TERR, SHAWNEE MISSION, 66208
BUCKINGHAM,ULISA D, 3107 PUCKETT, KANSAS CITY, 66103
BUHR,BRUCE R, 9800 W 56TH, SHAWNEE MISSION, 66203
BURKE,MICHAEL J, 1450 N FAIRMOUNT, WICHITA, 67208
CAMERON,JULIE F, 3600 STATE LINE, KANSAS CITY, 66103
CARNEY,LISA ANN, 2104 W 41ST, KANSAS CITY, 66103
CARRIAGA,MARISA T, 3404 KARNES, KANSAS CITY, 64111
CARRO,TONY L, C/O BOX 38, WINFIELD, 67156
CARTY,RUSSEL W, 6110 W 51ST #4, SHAWNEE MISSION, 66202
CASIDY,JERRY A, 9708 WALMER, SHAWNEE MISSION, 66212
CASTEEN,JOHN A, 3909 BOOTH #3, KANSAS CITY, 66103
CASTERLINE,JOHN B, 1010 APACHE, WICHITA, 67207
CATO,TERI A, 1249 N TOPEKA, WICHITA, 67214
CAVANAUGH,TIMOTHY B, 8501 REINHARDT LN, SHAWNEE MISSION, 66206
CHALABI,PHILLIP M, 11814 W 66TH, SHAWNEE MISSION, 66203
CHERAY,JAMES A, 9401 W 81, SHAWNEE MISSION, 66204
CHIN,CRAIGHTON, 3030 EATON, KANSAS CITY, 66103
CHUNG,CLARA K, 3805 BOOTH, KANSAS CITY, 66103
CLARK,CHUCK, 55 JANSSEN PL, KANSAS CITY, 64109
CLARK,GORDON B, 4104 ADAMS, KANSAS CITY, 66103
CLARK,PERRY L, 3602 RAINBOW APT 302, KANSAS CITY, 66103
CLAY,MICHAEL J, 1263 S SAGEBRUSH CT, WICHITA, 67230
COADY,MARY ANN, 3915 BOOTH APT 7, KANSAS CITY, 66103
COBB,JEANNINE M, 1720 PARK PL, WICHITA, 67203
COHN,L ELIZABETH, 2314 S 14TH, KANSAS CITY, 66103
COLLINS,DAVID E, 3919 ADAMS, KANSAS CITY, 66103
COLLINS,JEFFREY S, 4333 OAK APT 3, KANSAS CITY, 64111
COLYER,JEFFREY W, 1100 6TH SW, WASHINGTON, 20024
CONANT,FERRILL R, 8515 LAKELAND DR, WICHITA, 67207
CONCANNON,CRAIG A, 921 N MILL, BELOIT, 67420
COOK,KAROLYN M, 3232 S CLIFTON #439, WICHITA, 67216
COOK,THEODORE R, 3232 S CLIFTON #439, WICHITA, 67216
COONROD,SCOTT A, 5009 LAMAR #5, SHAWNEE MISSION, 66202
COX,MARCIA M, 1985 AMIDON APT 812, WICHITA, 67203
COX,MICHAEL R, 4449 FRANCIS, KANSAS CITY, 66103
COX,REAGAN M, 1100 CTY LINE BL 12 APT 35, KANSAS CITY, 66103
CRAMPTON,KARME L, 2404 W 38TH, KANSAS CITY, 66103
CZAPANSKY,DESIREE K, 1435 BROOKFIELD, WICHITA, 67206
DADKHAH,NADER, 4145 FRANCIS, KANSAS CITY, 66103
DANIELS,PATRICIA W, 7016 ANTIOCH, SHAWNEE MISSION, 66204
DAVIS,BRADLEY E, 8214 W 101, SHAWNEE MISSION, 66212
DE WITT,BARBARA L, 2913 EATON, KANSAS CITY, 66103
DEAY,CHARLES J, 6601 W 55, SHAWNEE MISSION, 66202
DEITZ,RICHARD M, 5407 W 64TH TERRACE, SHAWNEE MISSION, 66208
DELWORTH,MARK G, 3806 STATE LINE, KANSAS CITY, 66103
DEPEW,CLIFFORD S, 923 COOLIDGE #3, WICHITA, 67203
DETAR NEWBERT,LE ANNE, PO BOX 41, BONNER SPRINGS, 66012
DIAZ,MARIA L, 4104 FRANCIS, KANSAS CITY, 66103
DICK,CAMERON R, 4112 FRANCIS, KANSAS CITY, 66103
DILLARD,SANDY R, 1519 N FAIRMONT, WICHITA, 67208
DINGES,DAVID L, 905 S GOUVERNEUR #302, WICHITA, 67207
DO, SON T, 9716 W 49TH PL, SHAWNEE MISSION, 66203
DOANE,JOHN F, 11547 GODDARD, SHAWNEE MISSION, 66210
DOERRY,KAREN E, 3751 BOOTH APT #1, KANSAS CITY, 66103
DORNHOFFER,JOHN L, 4117 ADAMS APT 301, KANSAS CITY, 66103
DOUGHERTY,WILLIAM S, 4309 FISHER, KANSAS CITY, 66103
DOWNARD,JAMES M, 2017 S PERSHING, WICHITA, 67218
DUGAN,DAVID L, 331 N ERIE, WICHITA, 67214
DUNFIELD,JAY A, 2000 W 36TH, KANSAS CITY, 66103
DWYER,JOHN E, 2417 S 24TH APT 08204, KANSAS CITY, 66106
DYER,DAVID S, 3838 RAINBOW #711, KANSAS CITY, 66103
EBRAHIMI,KAMILLE G, 1100 COUNTY LINE RD #4 - 2, KANSAS CITY, 66103
ECK,MARCI J, 351 S ERIE, WICHITA, 67211
EDMONDS,MARTA J, 4620 W 72ND, SHAWNEE MISSION, 66208
EDWARDS,KIMBERLY K, RT 1 BOX 965, BUCYRUS, 66013
EDWARDS,SHELLEY J, 8709 W 65TH STE 201, SHAWNEE MISSION, 66202
EGE,DAVID L, 2000 W 36TH, KANSAS CITY, 66103
EHLY,CHRISTOPHER J, 5301 LYDIA, KANSAS CITY, 64110
EISENHUT,RANDY E, 17 VENTURA, OLATHE, 66061
EKENGREN,HUGH I, 2525 W 38TH #1C, KANSAS CITY, 66103
ELANGOVAN,SUDHA, 14033 E GILBERT, WICHITA, 67230
ELCOCK,DAVID G, 3518 W 83RD APT 212, SHAWNEE MISSION, 66208
ELLIS,LAVERLE A, 202 N ROCK RD #1206, WICHITA, 67206
EMIG,MARK D, 5010 GLENWOOD #21, SHAWNEE MISSION, 66202
ENGEN,PHIL L, 2028 CHESTER, KANSAS CITY, 66103
ENNS,STEPHEN J, 5433 FOXRIDGE DR #305, SHAWNEE MISSION, 66202
ERDWIEN,BARBARA A, 3838 RAINBOW #410, KANSAS CITY, 66103
FALLING,TRENT L, 527 PERSIMMON DR, OLATHE, 66061
FAKHOURY,MARK, 4914 NE 37TH, KANSAS CITY, 64117
FANSHOURY,SHAWNETTE L, 3706 STATELINE, KANSAS CITY, 66103
FAST,GARY A, 3821 WESTLAWN, WICHITA, 67203
FEAGINS-ALEXANDER,SHIRLEY J, 557 S BROADVIEW, WICHITA, 67218
FELTS,ARTHUR D, 5143 MISSION RD, SHAWNEE MISSION, 66205
FITZPATRICK,PAMELA S, 3821 SPRINGFIELD APT 1B, KANSAS CITY, 66103
FLEER,GERALD K, 10900 OASIS CT #120B, SHAWNEE MISSION, 66203
FLUTER,GEORGE G, 1918 W 37TH, KANSAS CITY, 66103
FLUTY,STEVEN R, 6920 W 72ND, SHAWNEE MISSION, 66204
FRANK-GEIER,MARY S, 6025 W 50TH, SHAWNEE MISSION, 66202
FRANKLIN,MICHAEL D, 3913 ADAMS, KANSAS CITY, 66103
FRIESEN,SUSAN G, 384 S CLIFTON, WICHITA, 67218
FROST,ELIZABETH L, 343 N HOLYOKE, WICHITA, 67208
GABRIELLI JR,WILLIAM F, 4117 ADAMS #101, KANSAS CITY, 66103
GARCIA-FERRER,CIRA M, 9409 W 82ND, SHAWNEE MISSION, 66204
GARDINER,ROBERT C, 6315 W 75TH APT 10, SHAWNEE MISSION, 66204
GARRETT,DALE G, 3600 RAINBOW APT 312, KANSAS CITY, 66103
GAST,KRISTIE L, 3415 N 63RD, KANSAS CITY, 66104
GATSCHET,TIMOTHY P, 314 COMMERCIAL, SEDGWICK, 67135
GAYNES,STUART M, 2838 EATON, KANSAS CITY, 66103
GEIER,DAVID L, 3600 RAINBOW APT 313, KANSAS CITY, 66103
GEORGE,PAULA Y, 1045 FORREST CT #17, KANSAS CITY, 66103
GERNON,CROSBY, 3924 RAINBOW, KANSAS CITY, 66103
GERROND,LINDA L, 5201 HOWE DR, SHAWNEE MISSION, 66205
GILLENWATER,DAVID T, 621 S IDA, WICHITA, 67211
GILLET,MARK L, 9315 W 83RD TERR, SHAWNEE MISSION, 66212
GLEASON,JEFFREY J, 3806 STATE LINE, KANSAS CITY, 66103
GLOVER II,RICHARD M, 3142 W 46 AVE, KANSAS CITY, 66103
GOINS,BONNIE K, 15615 W 152ND TERR, OLATHE, 66062
GOLDBERG,JOHN M, 3242 W 43RD, KANSAS CITY, 66103
GRAHAM JR, ARNOLD R, 3824 BOOTH #12, KANSAS CITY, 66103
GRANGER,NATHAN D, 999 N SILVER SPRINGS APT 2107, WICHITA, 67212
GRATNY,LINDA L, RR 3 BOX 513, LEAVENWORTH, 66048
GREENWOOD,JOHN M, 3744 BOOTH APT 4, KANSAS CITY, 66103
GREENWOOD,MELANIE A, 1402 BURNS, WICHITA, 67203
GRELLINGER,BART A, 3609 E KELLOGG DR, WICHITA, 67218
GRIFFITT,WESLEY E, 4310 FRANCIS, KANSAS CITY, 66103
GRILLOT,MICHAEL B, 3511 ELMWOOD, WICHITA, 67218
GROSVALD,DOUGLAS E, 3744 BOOTH APT 4, KANSAS CITY, 66103
HALL,GARY D, 6910 W 52 PL APT 1A, SHAWNEE MISSION, 66202
HALLING,AMY C, 3916 SPRINGFIELD, KANSAS CITY, 66103
HALLING,KEVIN C, 3916 SPRINGFIELD, KANSAS CITY, 66103
HALVORSON,KARI J, 3035 PUCKETT RD APT 36, KANSAS CITY, 66103-1750
HAMPEL,JEFF A, 3919 ADAMS, KANSAS CITY, 66103
HAMPEL,KEVIN G, 2632 S MEAD, WICHITA, 67216
HANSON,ROBERT L, 6202 ONEIDA, WICHITA, 67208
HARDY,BRADFORD R, 3909 BOOTH #7, KANSAS CITY, 66103
HARRINGTON,ELAINE M, 3004 EATON, KANSAS CITY, 66103
HARTY,JEAN R, 14604 W 91ST PL, SHAWNEE MISSION, 66215
HEATON,KEITH M, 3915 BOOTH #5, KANSAS CITY, 66103
HEDDEN,RICHARD J, 8912 WENONGA, SHAWNEE MISSION, 66206
HEIT,JOSEPH A, 4319 BELL, KANSAS CITY, 64111
HELLEN,WESLEY D, 1931 W LAWRENCE CT, KANSAS CITY, 66103
HELLER,DEANNA L, 4216 BELL, KANSAS CITY, 64111
HELLMAN,DAVID W, 224 N FERN, WICHITA, 67203
HELM,DOUGLAS S, 6568 W 51ST, SHAWNEE MISSION, 66202
HENDERSON,BRYAN K, 3600 RAINBOW APT 312, KANSAS CITY, 66103
HENRY,ROBERT M, 5011 PAWNEE, SHAWNEE MISSION, 66205
HENSON,STEVEN R, 608 RANDOM RD, HESSTON, 67062
HERSH,CHRISTOPHER K, 3030 W 9TH, LAWRENCE, 66044
HICKERT,MAUREEN C, 3829 TERRACE APT 4, KANSAS CITY, 64111
HINSHAW,DARLA J, 2613 ESSEX, KANSAS CITY, 66103
HOLDEN,JILL K, 11188 HENSON, SHAWNEE MISSION, 66210
HON,DAVID E, 803 N SHERIDAN STE 1901, WICHITA, 67203
HOPPOCK,KEVIN C, 1214 S PERSHING, WICHITA, 67218
HORNER,JILLIAN E, 4443 SPRINGFIELD, KANSAS CITY, 66103
HORTON,GREG A, 4105 ADAMS, KANSAS CITY, 66103
HOURIGAN,RICHARD J, 4117 ADAMS #314, KANSAS CITY, 66103
HOWELL,STEVEN J, 621 S IDA, WICHITA, 67211
HRABIK,BRENT A, 6206 CRAIG, SHAWNEE MISSION, 66202
HUDGINS,MARK A, 4415 FRANCIS, KANSAS CITY, 66103
HUGHES,STEVEN, 4327 WYOMING, KANSAS CITY, 64111
HUNNINGHAKE,DENISE A, 3900 BOOTH #8, KANSAS CITY, 66103
HUNT,BRIAN J, 3828 BOOTH #6, KANSAS CITY, 66103
HURLBUT,KEVIN M, 3838 RAINBOW #605, KANSAS CITY, 66103
HUTCHISON,SCOT M, 4462 FRANCIS, KANSAS CITY, 66103
HUTTERER,ANGELA J, 9211 E HARRY #1802, WICHITA, 67207
IMLAY,BRIAN, 3630 BELL, KANSAS CITY, 64111
JAEGER,MARY G, 1554 N PINCREST, WICHITA, 67208
JALALI,MEHDI, 1675 S 31ST, KANSAS CITY, 66106
JANSSEN,KATHERINE L, 1157 S WEBB #1157, WICHITA, 67207
JENAB,JOHN, 1903 W 70TH TERR, SHAWNEE MISSION, 66208
JENKINS,DE ANN R, 1945 N ROCK RD #2223, WICHITA, 67206

JENSEN JR,JOHN T, 6740 W 52ND PL 1A, SHAWNEE MISSION, 66202
 JOHNSON,KEITH A, 7630 WINDSOR DR, SHAWNEE MISSION, 66208
 JOHNSON,LINDA M, 8905 MOHAWK LN, SHAWNEE MISSION, 66206
 JOHNSON,ROBERT C, 10912 W 100TH TERR, SHAWNEE MISSION, 66214
 JONES,DAVID B, 9808 GLENWOOD, SHAWNEE MISSION, 66212
 JORDAN,JANET C, 617 E 72ND TERR, KANSAS CITY, 64131
 JOSLIN,CHARLIE G, 3103 BARNETT APT C, KANSAS CITY, 66102
 JUNG,SIMON CY, 8759 GOODARD, SHAWNEE MISSION, 66214
 KAHRSS,GREG, 3827 TERRACE #10, KANSAS CITY, 64111
 KALIN,CINDI A, 10605 W 61ST, SHAWNEE MISSION, 66203
 KALIVAS,LINDA L, 12300 PAWNEE LN, SHAWNEE MISSION, 66209
 KASTER,STEVEN D, 1033 W 38TH, KANSAS CITY, 64111
 KAUER,CURTIS D, 4174 CAMBRIDGE, KANSAS CITY, 66103
 KELLEY,MARSHALL D, 7232 GRANDVIEW DR, SHAWNEE MISSION, 66204
 KELLY,JIM, 3909 ADAMS, KANSAS CITY, 66103
 KELLY,MICHELE, 6427 W 51ST TERR, SHAWNEE MISSION, 66202
 KENAGY,ROBERT S, 642 SYLVAN, WICHITA, 67218
 KENDALL,MARK A, 323 N HAMPTON, WICHITA, 66103
 KENNEDY,CHRISTOPHER S, 3562 PENNSYLVANIA #1, KANSAS CITY, 64111
 KERWIN,MERRITT M, 2606 W 50TH TERR, SHAWNEE MISSION, 66205
 KIM,SUCHA, 1705 BELAIR DR, JUNCTION CITY, 66441
 KIMPLE,KRIS G, 2008 S ESTELLE, WICHITA, 67211
 KIMURA,LYLA S, 3504 W 85TH, SHAWNEE MISSION, 66206
 KIMURA,STEPHEN H, 3504 W 85TH, SHAWNEE MISSION, 66206
 KING,BRADLEY S, 808 N 12TH, ARKANSAS CITY, 67115
 KING,TERESA M, 4309 ADAMS, KANSAS CITY, 66103
 KIRCHNER,LAURA L, 3838 RAINBOW APT 208, KANSAS CITY, 66103
 KIRK,JOHN M, 3909 BOOTH APT 10, KANSAS CITY, 66103
 KLEIN,THOMAS C, 3724 BOOTH APT 18, KANSAS CITY, 66103
 KOEHN,DANIEL J, 3748 CAMBRIDGE #B, KANSAS CITY, 66103
 KOERPER,KARL, 4920 BELL, KANSAS CITY, 64112
 KRATZ,DONALD P, 302 N BOOKSIDE, WICHITA, 67208
 KUBIN,SUSAN D, 411 S CHAUTAUQUA, WICHITA, 67211
 KUMMER,ANTHONY J, 4107 BELL, KANSAS CITY, 64111
 LASNIER,JOSEPH M, 4309 FISHER, KANSAS CITY, 66103
 LAUDERT,SUSAN E, 2021 BROADMOOR #404, WICHITA, 67206
 LAWHAD,JEFF D, 3033 PUCKETT RD #18, KANSAS CITY, 66103
 LEAR,REX V, 400 W CENTRAL STE 1514, WICHITA, 67203
 LEHMAN,KARL D, 2011 FEDERAL, KANSAS CITY, 66103
 LESSIN,DIANNA L, 3821 WYOMING, KANSAS CITY, 64111
 LETOURNEAU,EDWARD N, 5078 SKYLINE DR, SHAWNEE MISSION, 66205
 LIBEL,ROY, 2710 W 51ST TER, SHAWNEE MISSION, 66205
 LICHTY,DAN M, 6412 W 77TH TERR, SHAWNEE MISSION, 66204
 LILLICH,MAUREEN A, 5046 CLARK DR, SHAWNEE MISSION, 66205
 LINDSTROM,LORI A, 4100 WYOMING, KANSAS CITY, 64111
 LONEY,PAUL D, 3814 STATE LINE, KANSAS CITY, 66103
 LONG,TERESA D, 4417 JARBOR, KANSAS CITY, 64111
 LOPEZ,MARIA I, 4104 FRANCIS, KANSAS CITY, 66103
 LORSBACH,ROBERT B, 18850 S WEAVERLY RD, GARDNER, 66030
 LORTZ,PHILIP W, 3628 SPRINGFIELD, KANSAS CITY, 66103
 LOWETT,BRENT R, 73 JANSSSEN PL #3, KANSAS CITY, 64109
 LUALLIN,SCOTT R, 3602 RAINBOW #308, KANSAS CITY, 66103
 LUBETICH JR,JOHN F, 3600 RAINBOW STE 316, KANSAS CITY, 66103
 LUCAS,EDDY D, 2425 W 43RD, KANSAS CITY, 66103
 LUCKEROTH,LEAH L, 905 W 12TH N, WICHITA, 67203
 LYLE,LINDA S, 1207 FRANKLIN #3, WICHITA, 67203
 MADDEN,CATHERINE E, 9100 E HARRY #708, WICHITA, 67207
 MADISON,RANDALL W, 7711 GARNETT, SHAWNEE MISSION, 66215
 MADRIGAL,MARILU, 3580 RAINBOW #821, KANSAS CITY, 66103
 MAGEE,SHAWN M, 6105 W 54TH TERR, SHAWNEE MISSION, 66202
 MAGERS,STACEY L, 3904 WYOMING 3N, KANSAS CITY, 64111
 MALONE,DAVID G, 4801 FAIRMONT, KANSAS CITY, 64112
 MARGOLIS,MICHAEL T, 3810 MERCIER, KANSAS CITY, 64111
 MARSHALL,STEPHEN R, 1157 S WEBB STE 2116, WICHITA, 67207
 MASSOTH,SUE V, 1712 SW CHEYENNE, TOPEKA, 66604
 MATZEN,TED A, 7143 CHEROKEE RD, SHAWNEE MISSION, 66208
 MAUCH,WILLIAM D, 2311 MARTY #F, KANSAS CITY, 66103
 MAVCE,JAMES A, 3820 BOOTH APT #1, KANSAS CITY, 66103
 MCCLEAY,PETER D, 6433 WASHINGTON, KANSAS CITY, 64113
 MCGREGOR,PATRICK E, 3550 RAINBOW APT 123, KANSAS CITY, 66103
 MCHENRY,TERESSA J, 343 N HOLYOKE, WICHITA, 67208
 MCKINLEY,DOUGLAS L, 5733 HAUSER, SHAWNEE MISSION, 66212
 MCQUITT,CHRISTOPHER K, 3023 PUCKETT RD #22, KANSAS CITY, 66103
 MCQUITT,DWAYNE A, 3824 BOOTH APT #10, KANSAS CITY, 66103
 MEIER,PATRICIA A, 384 S CLIFTON, WICHITA, 67218
 MELHAM,THOMAS J, 3600 RAINBOW #317, KANSAS CITY, 66103
 MELROSE,ZIANA A, 10801 W 75TH TERR #2, SHAWNEE MISSION, 66214
 MENNINGER,BRENT O, 3218 EATON, KANSAS CITY, 66103
 MENZIE,LISA D, 4161 CAMBRIDGE, KANSAS CITY, 66103
 MERFIELD,CHRISTOPHER D, 7405 BELINDER, SHAWNEE MISSION, 66208
 MESSAMORE,DEBRA L, 2308 S BELMONT, WICHITA, 67218
 METZ,BRIAN A, 4134 EATON #3, KANSAS CITY, 66103
 MEYER,MARK C, 3737 EATON, KANSAS CITY, 66103
 MEYERS,JOHN J, 3901 BOOTH APT 3, KANSAS CITY, 66103
 MILLER,DAVID A, 3570 RAINBOW #622, KANSAS CITY, 66103
 MILLER,KEVIN E, 7411 E 18TH, WICHITA, 67206
 MILLS,CRAIG G, 2007 FEDERAL, KANSAS CITY, 66103
 MILLS,KIRK C, 611 BROADVIEW, WICHITA, 67208
 MITCHELL MD,SUE M, 1019 W 38TH, KANSAS CITY, 64111
 MITCHELL,DEANNA SUE, 1100 COUNTY LINE RD 8-9, KANSAS CITY, 66103
 MODELL,ELLEN M, 5210 W 69TH, SHAWNEE MISSION, 66208
 MONTERO,JR,CARLOS, 4122 THOMPSON APT 8, KANSAS CITY, 66103
 MOORE JR,DENNIS F, 7439 TANGLEWOOD, WICHITA, 67206
 MOORE,ROBERT M, 3737 EATON, KANSAS CITY, 66103
 MOORE,THOMAS A, 3919 ADAMS, KANSAS CITY, 66103
 MORGAN,MICHAEL C, 10216 OAKRIDGE DR, SHAWNEE MISSION, 66212
 MORGAN,MITCH A, 4174 CAMBRIDGE, KANSAS CITY, 66103
 MOYES,ANDREW L, 5101 MISSION, SHAWNEE MISSION, 66205
 MUKERJEE,SANDEEP, 3734 CAMBRIDGE, KANSAS CITY, 66103
 MURPHY,TIMOTHY P, 4730 JARBOR, KANSAS CITY, 64112
 MURPHY,WILLIAM R, 3740 BOOTH #8, KANSAS CITY, 66103
 NADER,DADKAH, 4145 FRANCIS, KANSAS CITY, 66103
 NAGLE,KEITH J, 3747 CAMBRIDGE #2, KANSAS CITY, 66103
 NAZARIO,LILIANA E, 8170 HALSEY, SHAWNEE MISSION, 66215
 NEASE JR,DONALD E, 649 N HILLSIDE, WICHITA, 67214
 NELSON,BRENDA S, 4143 CAMBRIDGE, KANSAS CITY, 66103
 NELSON,CHARLES G, 7217 BEVERLY, SHAWNEE MISSION, 66204
 NELSON,MARIAN K, 400 W CENTRAL NORTH #1204, WICHITA, 67203
 NELSON,MARK THEODORE, 2425 43RD, KANSAS CITY, 66103
 NELSON,NANCY A, 1423 HIGHLAND DR, CONCORDIA, 66901
 NEUFELD,BRENDA G, 3717 STATE LINE, KANSAS CITY, 64111
 NEWLIN,PHILIP L, 910 W 25TH SOUTH, WICHITA, 67217
 NEWTH,ROBERT C, 7656 COLONIAL DR, SHAWNEE MISSION, 66208
 NICHOLS,JON CHRISTOPHER, 6140 W 51ST APT 3, SHAWNEE MISSION, 66202
 NIGH,STEPHEN S, 4700 W 66TH, SHAWNEE MISSION, 66208
 NIGHTINGALE,DIANE J, 404 CHEROKEE DR, KECHI, 67067

NIXON, DAVID, 2525 ESSEX, KANSAS CITY, 66103
 NORMAN,BENJAMIN R, 1402 E CATALINA, WICHITA, 67216
 O'DONNELL,JANAT E, 32 NORFOLK, WICHITA, 67208
 OEHME,STEPHEN F, 3915 BOOTH #9, KANSAS CITY, 66103
 OLSEN,TIMOTHY W, 39TH & RAINBOW BOX 414, KANSAS CITY, 66103
 OLSON,CAROLYN E, 4316 ADAMS, KANSAS CITY, 66103
 OLSON,CAROLYN E, UKSM-WICHITA, WICHITA, 67214
 ONG,CATHERINE M, 6001 W 90TH TERR, SHAWNEE MISSION, 66207
 OSE,KEVIN J, 3915 BOOTH #12, KANSAS CITY, 66103
 OTTINGER,CHRISTOPHER M, 3838 RAINBOW APT 204, KANSAS CITY, 66103
 OVERFIELD,A SCOTT, 3580 RAINBOW APT #828, KANSAS CITY, 66103
 OWEN,MEDGE D, 4107 BELL, KANSAS CITY, 64111
 OYLER,JONATHAN M, PO BOX 727, WELLSVILLE, 66092
 PAIGE,ANGELA A, 2424 W 40TH #5, KANSAS CITY, 66103
 PALMER,APRIL L, 4104 FRANCIS, KANSAS CITY, 66103
 PALMER,GLEN L, 3812 BOOTH APT 10, KANSAS CITY, 66103
 PARKER,JULIE A J, 4121 THOMPSON APT 8, KANSAS CITY, 66103
 PARKS,JON C, 3118 EATON, KANSAS CITY, 66103
 PARSONS,JULIE A, 2323 N WOODLAWN #623, WICHITA, 67220
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 PATRON,RUFINO B, 3915 BOOTH APT 11, KANSAS CITY, 66103
 PAUL,DAVID M, 3915 BOOTH #8, KANSAS CITY, 66103
 PAULEY,JANET K, 4145 ADAMS, KANSAS CITY, 66103
 PAULS,DAVID G, 1234 FIGG, WICHITA, 67213
 PAULS,SCOTT W, 3123 WYANDOTTE CIR #D, KANSAS CITY, 66106
 PAVELONIS,JOEL D, 5011 LAMAR STE 3, SHAWNEE MISSION, 66202
 PEARSON,MARK A, 5606 FLOYD APT D, SHAWNEE MISSION, 66202
 PENA,ALEJANDRO J, 4122 THOMPSON, KANSAS CITY, 66103
 PENN,CHRISTOPHER C, 211 N BATTIN, WICHITA, 67208
 PENNER,TIMOTHY M, 3226 COUNTRY CLUB PL, WICHITA, 67208
 PERSONS,DIANE L, 1002 W 78TH, KANSAS CITY, 64114
 PETERS,CHRISTOPHER C, 6740 W 52ND PLACE #1A, SHAWNEE MISSION, 66202
 PETERS,ERIC A, 400 W CENTRAL APT 1211, WICHITA, 67203
 PETERSEN,MARK I, 4956 ADAMS, SHAWNEE MISSION, 66205
 PINKERTON,LYNNE E, 2330 N OLIVER #2940, WICHITA, 67220
 PINKHAM,CHRIS M, 1802 W 41ST #1W, KANSAS CITY, 64111
 PLUMB,RENEE L, 4400 ADAMS, KANSAS CITY, 66103
 PODREBARAC,FRANCIS A, 5101 RIGGS, SHAWNEE MISSION, 66202
 POKORNY,JOHN C, 3820 BOOTH #11, KANSAS CITY, 66103
 POOLE,EDWARD C, 2745 N 87TH, KANSAS CITY, 66109
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 RAY,LARRY D, 10851 GLENWOOD, SHAWNEE MISSION, 66211
 REDDY,BEENA M, 7329 OXFORD CT, WICHITA, 67226
 REEDER,STEPHEN M, 7506 LAMAR #50, SHAWNEE MISSION, 66208
 REICHENBERGER,RONALD J, 3820 BOOTH APT 2, KANSAS CITY, 66103
 REISWIG,GARY W, 4112 FRANCIS, KANSAS CITY, 66103
 REISWIG,JEFFREY SCOTT, 2004 WESTFIELD, WICHITA, 67212
 REISZ,COLLEEN C, 2220 W 71ST, SHAWNEE MISSION, 66208
 RETHORST,RICHARD D, 1100 COUNTY LINE RD #31 BLDG 8, KANSAS CITY, 66103
 REUSSNER,LEE A, 3915 BOOTH #12, KANSAS CITY, 66103
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 RIESENMY,BRANDON D, 5538 REEDS, SHAWNEE MISSION, 66202
 RING,KEVIN F, 5933 ELMONT, SHAWNEE MISSION, 66205
 ROBERSON,CHERYL L, 3732 BOOTH APT 10, KANSAS CITY, 66103
 ROBINSON,RICHARD K, 2904 W 46TH, KANSAS CITY, 66103
 RODRIGUEZ,BEATRIZ M, 550 W CENTRAL, WICHITA, 67203
 RONSICK,STEVEN O, 2811 W 44TH, KANSAS CITY, 66103
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 ROWDON,GREGORY A, 8830 PFLUM RD APT 203, SHAWNEE MISSION, 66215
 ROY,RISE J, 2316 SW MAYFAIR PL, TOPEKA, 66611
 RUHL,CONSTANCE E, 9223 W 79TH #92, SHAWNEE MISSION, 66204
 RUPP,JAMES CLARKE, 4146 BOOTH PL APT B12, KANSAS CITY, 66103
 RUTHERFORD,MARK A, 5805 WALMER, SHAWNEE MISSION, 66202
 SACK,JOSEPH M, 1704 W 32ND NORTH, WICHITA, 67204
 SANDENO,CRAIG A, 10046 ROSEHILL, SHAWNEE MISSION, 66215
 SANDERS,JAMES E, 3725 STATE LINE, KANSAS CITY, 64111
 SANDERS,KARL A, 1019 W 38TH #3, KANSAS CITY, 64111
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 SCAMMAN,AMY C, 3808 BOOTH APT 7, KANSAS CITY, 66103
 SCHLOESSER,ANNE C, 3580 RAINBOW APT #801, KANSAS CITY, 66103
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 SCHMIDT,MARTY L, 343 N HOLYOKE, WICHITA, 67208
 SCHOWENGERDT,ANDREW W, 5123 E TRUMAN, KANSAS CITY, 64127
 SCHOWENGERDT,DANIEL B, 4101 FRANCIS, KANSAS CITY, 66103
 SCHROEDER,PATRICK L, 3804 BOOTH #7, KANSAS CITY, 66103
 SCHROFF,GREGORY P, 3715 CAMBRIDGE, KANSAS CITY, 66103
 SCHUPP,ELIZABETH A, 7406 FLINT APT 102, SHAWNEE MISSION, 66203
 SCHUYLER,GREGG T, 3807 BOOTH, KANSAS CITY, 66103
 SCOTT,STEVE G, 1310 MANHEIM RD, KANSAS CITY, 64109
 SCROGGIE,DANIEL J, BOX 158, PAOLA, 66071
 SEGRAVES,STEVEN D, 7800 GLENWOOD, SHAWNEE MISSION, 66204
 SEIDEL,DONALD R, 550 NIMS STE 239, WICHITA, 67203
 SEIFERT,EARNEST D, 1945 N ROCK RD #1105, WICHITA, 67206
 SEYB,STACY T, 5206 SYCAMORE, SHAWNEE MISSION, 66205
 SHAVER,TIM, 1129 S TERRACE, WICHITA, 67218
 SHAW,HOWARD A, 4133 STATE LINE, KANSAS CITY, 64111
 SHAW,PAMELA K, 9909 W 49TH PL, SHAWNEE MISSION, 66203
 SHEEHAN,MAUREEN H, 3504 W 85, SHAWNEE MISSION, 66206
 SHEPARD,SHELLEY M, 3701 W 77TH, SHAWNEE MISSION, 66208
 SHERBON,MARY LOU, 1000 CHESTNUT, DERBY, 67037
 SHERMAN,DENISE I, 600 S KOKOMO, DERBY, 67037
 SHULTZ,WILLIAM H, 9400 ENSLEY LANE, SHAWNEE MISSION, 66206
 SHUMARD,CRAIG J, 4915 E GILBERT, WICHITA, 67218
 SIEG,KARL G, 6716 W 76TH #A, SHAWNEE MISSION, 66209
 SIMENS,CHARLOTTE A, 916 W NOBLE, LYONS, 67554
 SIMON,CRAIG A, 3033 PUCKETT #19, KANSAS CITY, 66103
 SIMONY,M ANN, 5020 SOUTHRIDGE, SHAWNEE MISSION, 66205
 SMARDO JR,FRED L, 6610 NALL, KANSAS CITY, 66202
 SMITH,MICHAEL L, 3932 ADAMS #18, KANSAS CITY, 66103
 SNIDER,BRUCE B, 4464 FISHER, KANSAS CITY, 66103
 SNIDER,JOHN M, 4016 BOOTH, KANSAS CITY, 66103
 SNYDER,JULIE, 3739 CAMBRIDGE, KANSAS CITY, 66103
 SNYDER,MARK G, 3810 MERCIER, KANSAS CITY, 64111
 SOMMERFIELD,DAVID L, 2100 W 48TH, SHAWNEE MISSION, 66205
 SOUTHERN,FREDRICK N, 3838 RAINBOW APT 103, KANSAS CITY, 66103
 SPILKER,CYNTHIA A, 4136 BOOTH, KANSAS CITY, 66103
 SPRADLIN,MICHAEL L, 4928 ADAMS, SHAWNEE MISSION, 66205

SPRINGER, MARK J, 2323 N WOODLAWN #302, WICHITA, 67220
 STANLEY, BRAD K, 5004 BROADMOOR, SHAWNEE MISSION, 66202
 STANLEY, KENNETH E, 6909 STONEGATE LN, WICHITA, 67206
 STARKEY, DAVID J, 630 N PERSHING, WICHITA, 67208
 STARR, STEVEN K, 3820 BOOTH #9, KANSAS CITY, 66103
 STAUDACHER, TIMOTHY P, 9119 W 91ST TERR, SHAWNEE MISSION, 66212
 STECHSCHULTE JR, DANIEL J, 3907 ADAMS, KANSAS CITY, 66103
 STEEVES, KIMBERLY J, 3808 BOOTH #9, KANSAS CITY, 66103
 STEINBERGER, CRISTINE C, 7603 MONROVIA, SHAWNEE MISSION, 66216
 STEWART, DANIEL L, 550 N HILLSIDE, WICHITA, 67214
 STINGO, ANDREW J, 5708 W 164TH, STILLWELL, 66085
 STONE, CHRIS D, 1052 STINE LN, KANSAS CITY, 66103
 STRAIN, LORRAINE L, 144 S GREEN, WICHITA, 67211
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 STUART, SCOTT P, 1832 S 32ND, KANSAS CITY, 66106
 STUBLER, DANIEL K, 3942 ADAMS APT 17, KANSAS CITY, 66103
 STUEVER, KEVIN J, 4603 BELL, KANSAS CITY, 64112
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 SWEAZY, SCOTT M, 5010 GLENWOOD #21, SHAWNEE MISSION, 66202
 SWEET, LEIGHTON J, 2315 MARTY, KANSAS CITY, 66103
 TACKETT, ROBERT J, 6111 OAKWOOD DR, WICHITA, 67208
 TALBERT, TIMOTHY C, 900 N WACO APT B 104, WICHITA, 67203
 TAPHORN, ANN M, 3731 EATON, KANSAS CITY, 66103
 TARANTINO, CELESTE A, 3704 CAMBRIDGE, KANSAS CITY, 66103
 TEETER, CAROLYN NAN, 3708 CAMBRIDGE, KANSAS CITY, 66103
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 TETER, KENNETH E, 128 S ESTELLE, WICHITA, 67211
 THOMAS, STANLEY M, 6202 ROBINSON #4, SHAWNEE MISSION, 66211
 THORNTON III, FOXHALL P, 8402 GRANDVIEW LANE, SHAWNEE MISSION, 66212
 THORNTON, CAROLYN SUE, 8532 BENSON, SHAWNEE MISSION, 66212
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 TIPTON, KYLE M, 4144 BOOTH PL #7, KANSAS CITY, 66103
 TOLLEFSON, DENISE D, 801 E ARMOUR #506, KANSAS CITY, 64109
 TONKOWICZ, PATRICIA A, 5811 ANTIOCH, SHAWNEE MISSION, 66202
 TRIMMER, KENNETH J, 137 N GREEN, WICHITA, 67214
 TROWBRIDGE, DENISE R, 12606 W 110 TERR, SHAWNEE MISSION, 66210
 TSEN, ANDREW C, 4449 FRANCES, KANSAS CITY, 66103
 TURKLE, JANET K, 506 RIVERDALE, MULVANE, 67110
 TURNER, ROBERT N, 5424 EDWINISTER, WICHITA, 67212
 TURNER, WADE A, 4305 S ELIZABETH #4, WICHITA, 67217
 UNRUH, LINDA SUE, 6222 ROBINSON APT #4, SHAWNEE MISSION, 66202
 VAN DE VEER, SCOTT M, 1322 W 40TH, KANSAS CITY, 64111

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 VASUDEVAN, GOPI, 616 N BLUFF APT 205, WICHITA, 67208
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 WARDEN, SUSAN K, 3028 EATON, KANSAS CITY, 66103
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 WATERS, AARON T, 5715 HORTON, SHAWNEE MISSION, 66202
 WAXMAN, STEVE, 12516 W 85TH TERR, SHAWNEE MISSION, 66215
 WEINGART, JAMES H, 4717 W 70TH, SHAWNEE MISSION, 66208
 WEISHAAR, PAUL D, 2427 CRAWFORD, WICHITA, 67217
 WELLING, PAUL A, 6105 W 54 TERR, SHAWNEE MISSION, 66202
 WELTON, THOMAS C, 11504 BALLANTINE, SHAWNEE MISSION, 66210
 WENDELBURG, BLAKE E, 4412 STATE LINE RD, KANSAS CITY, 66103
 WENGER, CHARLES B, 3744 BOOTH #7, KANSAS CITY, 66103
 WENGER, CHARLES B, 3744 BOOTH #6, KANSAS CITY, 66103
 WETZEL, MARK D, 4172 CAMBRIDGE, KANSAS CITY, 66103
 WETZEL, ORVILLE R, 3932 ADAMS APT 22, KANSAS CITY, 66103
 WEYDERT, JOY A, 4134 EATON, KANSAS CITY, 66103
 WHEELER, JAMES A, 334 N QUENTIN #2, WICHITA, 67208
 WIENS, JONATHAN G, 4117 ADAMS APT 213, KANSAS CITY, 66103
 WIENS, LYNN A, 8828 WAYNE, KANSAS CITY, 64131
 WIENS, TIMOTHY K, 510 SE 2ND ST, NEWTON, 67114
 WILLIAMS, CARL M, 6910 W 52 PL APT 1A, SHAWNEE MISSION, 66202
 WILLIAMS, MICHAEL K, 4103 BOOTH, KANSAS CITY, 66103
 WILLIAMS, NANCY J, 3816 STATE LINE, KANSAS CITY, 66103
 WILLIAMS, TERI L, 3815 SPRINGFIELD APT 1C, KANSAS CITY, 66103
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 WILSON, LORI J, 5321 FOXRIDGE DR APT 201, SHAWNEE MISSION, 66202
 WINEINGER, DAVID K, 9426 REEDER, SHAWNEE MISSION, 66214
 WOODROOF, JANET M, 4124 THOMPSON APT 11, KANSAS CITY, 66103
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 WRIGHT, CHRISTOPHER, 4449 FRANCES, KANSAS CITY, 66103
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 YOUNG, JEFFREY L, 5715 HORTON, SHAWNEE MISSION, 66202
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Principles of MEDICAL ETHICS

Preamble:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

- I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
- II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
- V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
- VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

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July 20-24, 1980**





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INDICATIONS AND USAGE: Edema associated with congestive heart failure, hepatic and renal disease, including the nephrotic syndrome.

Almost equal diuretic response occurs after oral and parenteral administration of Bumex. If impaired gastrointestinal absorption is suspected or oral administration is not practical, Bumex should be given by the intramuscular or intravenous route.

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CONTRAINDICATIONS: Anuria. Hypersensitivity and in patients in hepatic coma or in states of severe electrolyte depletion. Although Bumex can be used to induce diuresis in renal insufficiency, any marked increase in blood urea nitrogen or creatinine, or the development of oliguria during therapy of patients with progressive renal disease, is an indication for discontinuation of treatment.

WARNINGS: Dose should be adjusted to patient's needs. Excessive doses or too frequent administration can lead to profound water loss, electrolyte depletion, dehydration, reduction in blood volume and circulatory collapse with the possibility of vascular thrombosis and embolism, particularly in elderly patients.

Prevention of hypokalemia requires particular attention in patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis and ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, certain diarrheal states, or other states where hypokalemia is thought to represent particular added risk to the patients.

In patients with hepatic cirrhosis and ascites, sudden alterations of electrolyte balance may precipitate hepatic encephalopathy and coma. Treatment in such patients is best initiated in the hospital with small doses and careful monitoring of the patient's clinical status and electrolyte balance. Supplemental potassium and/or spirnalactone may prevent hypokalemia and metabolic alkalosis in these patients. In cats, dogs and guinea pigs, Bumex has been shown to produce ataxicity. Since Bumex is about 40 to 60 times as potent as furosemide, it is anticipated that blood levels necessary to produce ataxicity will rarely be achieved. The potential for ataxicity increases with intravenous therapy, especially at high doses.

Patients allergic to sulfonamides may show hypersensitivity to Bumex.

PRECAUTIONS: Measure serum potassium periodically and add potassium supplements or potassium-sparing diuretics, if necessary. Periodic determinations of other electrolytes are advised in patients treated with high doses or for prolonged periods, particularly in those on low salt diets.

Hyperuricemia may occur. Reversible elevations of the BUN and creatinine may occur, especially with dehydration and in patients with renal insufficiency. Bumex may increase urinary calcium excretion. Possibility of effect on glucose metabolism exists. Periodic determinations of blood sugar should be done, particularly in patients with diabetes or suspected latent diabetes. Patients should be observed regularly for possible occurrence of blood dyscrasias, liver damage or idiosyncratic reactions.

Especially in presence of impaired renal function, use of parenterally administered Bumex should be avoided in patients to whom aminoglycoside antibiotics are also being given, except in life-threatening conditions.

Drugs with nephrotoxic potential and bumetanide should not be administered simultaneously. Since lithium reduces renal clearance and adds a high risk of lithium toxicity, it should not be given with diuretics.

Prabenecid should not be administered concurrently with Bumex.

Concurrent therapy with indomethacin not recommended.

Bumex may potentiate the effects of antihypertensive drugs, necessitating reduction in dosage.

Interaction studies in humans have shown no effect on digoxin blood levels.

Interaction studies in humans have shown Bumex to have no effect on warfarin metabolism or on plasma prothrombin activity.

Pregnancy: Bumex should be given to a pregnant woman only if the potential benefit justifies the potential risk to the fetus.

Bumetanide may be excreted in breast milk.

Pediatric Use: Safety and effectiveness below age 18 not established.

ADVERSE REACTIONS: Muscle cramps, dizziness, hypotension, headache and nausea, and encephalopathy (in patients with preexisting liver disease).

Less frequent clinical adverse reactions are weakness, impaired hearing, rash, pruritus, hives, electrocardiogram changes, abdominal pain, arthritic pain, musculoskeletal pain and vomiting. Other clinical adverse reactions are vertigo, chest pain, ear discomfort, fatigue, dehydration, sweating, hyperventilation, dry mouth, upset stomach, renal failure, asterixis, itching, nipple tenderness, diarrhea, premature ejaculation and difficulty maintaining an erection.

Laboratory abnormalities reported are hyperuricemia, azotemia, hyperglycemia, increased serum creatinine, hypochloremia, hypokalemia, hyponatremia, and variations in CO₂ content, bicarbonate, phosphorus and calcium. Although manifestations of the pharmacologic action of Bumex, these conditions may become more pronounced by intensive therapy.

Diuresis induced by Bumex may also rarely be accompanied by changes in LDH, total serum bilirubin, serum proteins, SGOT, SGPT, alkaline phosphatase, cholesterol, creatinine clearance, deviations in hemoglobin, prothrombin time, hematocrit, platelet counts and differential counts. Increases in urinary glucose and urinary protein have also been seen.

DOSAGE AND ADMINISTRATION:

Oral Administration: The usual total daily dosage is 0.5 to 2.0 mg and in most patients is given as a single dose.

Parenteral Administration: Administer to patients (IV or IM) with GI absorption problem or who cannot take oral. The usual initial dose is 0.5 to 1 mg given over 1 to 2 minutes. If insufficient response, a second or third dose may be given at 2 to 3 hour intervals up to a maximum of 10 mg a day.

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Please see adjacent page for references and summary of product information.

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Special Feature: Malpractice

Malpractice '87: Status and Solutions	261
How to Avoid the 'Failure to Diagnose' Claim	265
Collateral Source Statute Held Unconstitutional	273
Proximal Tibial Valgus Osteotomy	267
KMS Newsletter	262a

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KANSAS MEDICINE

• The Journal Of The Kansas Medical Society •

Volume 88, Number 9, September 1987

Contents

Scientific Article

- Proximal Tibial Valgus Osteotomy
M. Bernhardt, M.D.; R. L. Plaster, M.D.; and
H. O. Marsh, M.D., Wichita 267
*The Veterans Administration Hospital Experience,
Wichita, Kansas, 1977-82*

Special Feature: Malpractice

- Malpractice '87: Status and Solutions
M. Martin Halley, M.D., J.D., Topeka 261
*Part one of a two-part update, including an overview
of the local and national situation*
- How to Avoid the 'Failure to Diagnose' Claim
Reprinted from *Loss Prevention Letter* 265
*Simple safeguards that can substantially reduce your
risk of suit for these claims*

Miscellaneous

- Auxiliary News 258
Classified Advertisements 274
Council Meetings 252
Cover Story 249
Editorial Comment: *Dilemma du Jour* 272
Information for Authors 260
KMS Newsletter 262a
Medicina et Lex: Collateral Source Statute
Held Unconstitutional 273
Physician Directory 276
Impaired Physician Program Directory 271
Vox Dox 250

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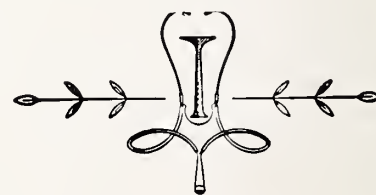
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Cover

Photo by Edwin D. Rathbun, M.D., taken with a Minolta Autofocus Rangefinder camera.

ACROSS THE COUNTRY, September brings one of the traditional rites of autumn: the reopening of schools. Just as certainly as schools open, thousands of children will be assigned the task of writing about what they did during the summer.

Current transportation facilities have inspired increasingly ambitious travel plans on the part of unwitting parents. The local scene, even in landlocked Kansas, still offers opportunities for both the young and their elders to get a sense of sea-going adventure by taking to the available rivers, lakes and creeks while they discover the wonders of nature as provided in numerous camping ventures of varying degrees of formality. The resulting experiences fulfill the assignment and provide food for memory which may be more enjoyable later in life than when recorded in the September account.

The reports may stress the worthy achievements, but better remembered will be those unexpected events such as the sudden deluges by night when novices find out they should have ditched their tent — or taken steps to exclude the pioneering types who elected to sleep under the stars only to come dragging in soaked blankets and selves with the pioneering spirit washed away. But after the rain — and creek — subside, there can be the unexpected excitement of finding an arrowhead or other artifact — or piece of rock one can pass off as such on the younger ones. For city types, there may be an introduction to such natural hazards as nettles and poison ivy. It is found that food cooked over the open fire, though underdone or burned and containing a certain amount of dirt or leaves, really tastes better than home cooking. There is fun in fixing a mud slide down the creek bank — giving way at night to the agony of itching, compounded by the accumulated sunburn. At some point, too, someone will become too venturesome and tip over the canoe, thereby shortening the life expectancies of the sponsors in proportion to the number of dunkies. Perhaps these sophisticated days have brought changes we are unaware of but we, at least, can read such events into Dr. Rathbun's scene of a relatively tranquil moment during a Scout canoeing trip on the Marais des Cygnes. — D.E.G.

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To the Editor:

The article ["Male Contraception and AIDS Prevention"] by M. Brown in the June 1987 issue of *Kansas Medicine* is right on target.

During the past year, when I served as President of the American College of Obstetricians/Gynecologists, our organization has been heavily involved in the issue of reducing unintended pregnancy. If we could achieve our goal of substantially reducing unintended pregnancy, particularly in the adolescent population, we also could reduce substantially the need for abortion in this country.

A program to promote sexual responsibility among the young — men as well as women — is a program that makes sense. The importance of stressing to young males their responsibility in using condoms has now been fairly well accepted by our society.

Although we have all become sensitized to the issue of sexually transmitted diseases, including AIDS, and how we need to better educate young people about the prevention of such diseases, we should also not lose sight of the fact that the prevention of unintended pregnancy is equally important.

Harry S. Jonas, M.D.
Immediate Past President
The American College of Obstetricians
and Gynecologists
207 Spruce Street
Lee's Summit, MO 64063

To the Editor:

M. Brown's recent article was a timely reminder of an often-ignored aspect of the teen pregnancy crisis. For every teen mother there is a teen, or older, father. Young men as well as young women should be counseled about the emotional, financial, and legal ramifications of initiating pregnancy. We should strive to see that they have some exposure to the day-to-day trials of parenthood prior to their becoming sexually active. Dr. C. Henry Kempe, who in 1962 exploded the conspiracy of silence about child abuse, in 1983 wrote: "Family life isn't a bed of roses as so many of our junior high 12 year olds think. Let them have a nursery school experience, housed on school sites. . . . It would help young boys to get to know a lot, too." Kempe recommended this stratagem not only as a deterrent

to child abuse, but to early and unwanted pregnancy as well.

Cindy Wood, M.D.
Assistant Professor
UKMC-KC

The author adds:

Some 1986 Kansas Department of Health and Environment figures have been released since I wrote my article. Analysis of those 1986 data continues to cry out for Kansas physicians to actively promote reversible contraception and AIDS prevention by heterosexually active males.

Sexual activity with children 15 years old or younger is a felony by Kansas statute 21-3503. Yet, . . . one girl only 13 years old had an induced abortion after she had one previous pregnancy, and one 15-year-old girl had an elective abortion after she had two previous pregnancies. . . . An indication that males help continue such patterns is the fact that one 16-year-old girl had at least her fourth elective abortion. . . .

Girls only 12-15 years old had 246 babies in 1986 (up from 230 babies during 1985). . . . Girls 17 years old or younger had 161 second babies, 19 third babies, and 1 fourth baby. . . .

For the 27th year in a row, males helped increase the percentage of all Kansas live births that were out of wedlock. In fact, based on the approximately 0.5 percent average annual increase over the previous 26 years, the jump from 14.8 percent in 1985 to 16.7 percent in 1986 represented a "four-year" increase in only one year!

The national figures on AIDS victims indicate that the toll from that disease continues to climb at a significant rate. As of July 7, 1987, 747 adult or adolescent females diagnosed with AIDS were infected with HIV through heterosexual contact; 701 adult or adolescent males found to have AIDS were infected through heterosexual contact; and, especially sad, 410 infants diagnosed with AIDS were infected perinatally. Sixty-eight percent of Kansans found to have AIDS during 1986 have died. Twenty-six percent of Kansas residents diagnosed with AIDS during 1987 have already died.



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CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3 , and decreasing T_3 .

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should

be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbital, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and lidocaine have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasisiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSEAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—Dosage must be individualized. Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—Dosage must be individualized. The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSEAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

REFERENCES:

1. INDERAL LA National Compliance Evaluation Program. Data on file, Ayerst Laboratories.
2. Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985; 145:1321-1323.

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This 80-bed, inpatient/outpatient facility is a joint venture project of Stormont-Vail Health Services and Continental Medical Systems. As

the largest independent rehabilitation care company in the U.S., Continental is developing or managing many facilities, including the acclaimed Braintree Hospital in Massachusetts and the Western Neuro Care Center in California.

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Council Meetings

Report of Meeting Held February 7, 1987

Franklin G. Bichlmeier, M.D., President, convened the council on February 7, 1987 at the Holiday Inn-Holidome, Salina, beginning at 10:00 a.m. Those present were Doctors:

Mark Bell
Frank Bichlmeier
F. Calvin Bigler
John Blank
L. Theil Bloom
Kenneth Boese
John Brockhouse
Clair C. Conard
Victor Eddy
James Gardner
Charles Glazzard
Jim Gleason
Donald Goering
Frank Griffith
Donald Hatton
Herman Hiesterman
Paul Kindling
David Leitch
Stephen Miller
John Rand Neuenschwander

Daniel Pauls
Eugene Pearce
Katherine Pennington
Terry Poling
Ed Rathbun
Ivan Rhodes
Timothy Scanlan
Clifton Schopf
Alex Scott
Richard Siemens
Arthur Snow
G. Rex Stone
Don Tillotson
Henry Travers
Wayne O. Wallace, Jr.
Linda Warren
Roger Warren
Darrell Werth
Donald Wikoff
James Wilson

Also present was Jeff Gleason, Medical Student.

Also present were Mary Belle Boyd, Betty Glover and Nancy Ramos, KMS Auxiliary representatives.

Staff present were Val Braun, Gary Caruthers and Jerry Slaughter.

Minutes of the September 20, 1986 meeting were approved. An update on the **professional liability** issue included the following reports: constitutional test of HB 2661; collateral source rule; and premiums availability and options.

The Council heard a report on the **1987 legislative issues**.

Ivan E. Rhodes, M.D., Chairman of the **Impaired Physicians Committee**, reported that an agreement with the Board of Healing Arts proposes to provide KMS the authority to investigate and to receive referrals from the public and from the Board of physician impairments. The confidentiality aspect of the program will be preserved, and records would not be subject to subpoena.

The Council reaffirmed the present KMS policy concerning the **prescribing** practices of non-physicians.

Roger D. Warren, M.D., Chairman, encouraged physicians and their spouses to continue to support the local legislators and **KaMPAC**.

Jimmie A. Gleason, M.D., reported that the Physicians Health Management Corporation of Ohio

was selected to conduct the feasibility study of an **alternative delivery system** in Kansas. This recommendation was approved by the Council.

Unified membership was discussed extensively.

KMS Services, Inc. has developed some programs, including the HCFA 1500 Unified Claim Form, which is available for purchase, and the Professional Liability Insurance Premium Finance Plan. An administrative contract has been signed with MEDISERVE, and clerical and administrative services have been offered to specialty societies. Two societies have indicated an interest in further discussions. Councilors were encouraged to suggest ideas for additional alternative programs.

A transfer of \$3,000 in unclaimed **refunds from the 1985 Blue Shield group health insurance program** to the Professional Liability Fund was authorized.

The Council then approved the revised **budget** as presented.

The Council heard an update on the **Alliance of State Physician Networks**. Since the initial meetings, CHAMPUS has determined that three demonstration projects will be conducted to determine whether changes in all the CHAMPUS programs should be implemented. The Kansas region is not under consideration at this time.

Linda D. Warren, M.D., reviewed the report on the **Young Physicians Section**, requesting the Council's support in the formation of a steering committee to determine interest in such a section. The report was approved.

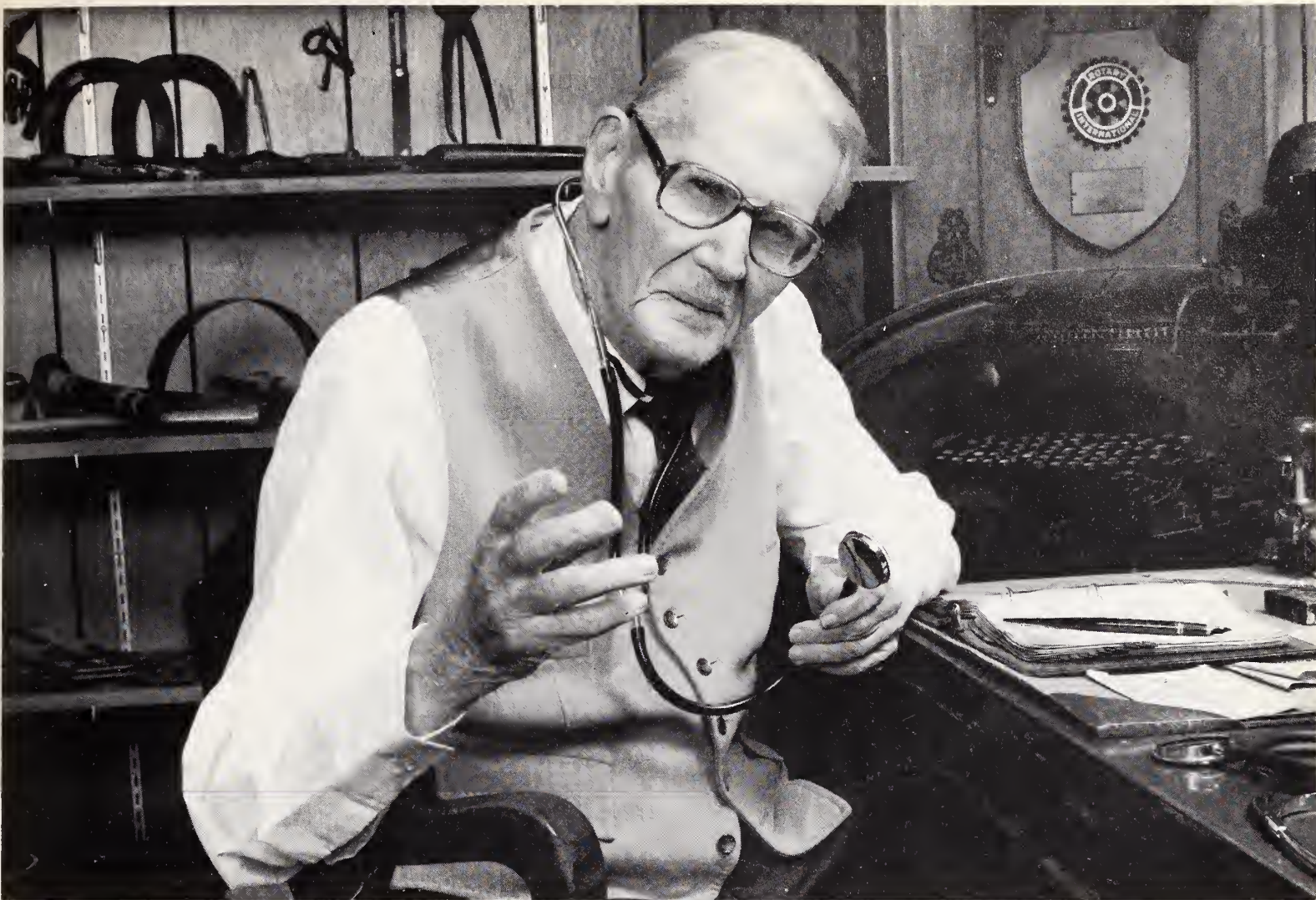
Plans for the **1987 Annual Meeting** were reviewed. The Council reaffirmed the policy of charging a \$15 registration fee.

In response to a question by Henry Travers, M.D., physicians were encouraged to contact their congressmen, asking them to support a resolution opposing the inclusion of **radiologists, anesthesiologists and pathologists** in the DRG payment to hospitals.

James Wilson, M.D., expressed his appreciation to KaMPAC for providing financial support for his state **legislative race**.

Medicare legislative hearings will be conducted in Wichita and Topeka in February. Physicians were urged to attend those meetings or provide written comments concerning the **Medicare** program.

The **next meeting** was scheduled for April 11,



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1987, in Topeka. The meeting adjourned at 1:00 p.m.

Report of Meeting Held April 11, 1987

Franklin G. Bichlmeier, M.D., President, called the meeting to order at 10:00 a.m., on Saturday, April 11, 1987, at the Topeka Holiday Inn-Holiday.

Those present were Doctors:

Larry R. Anderson
Mark G. Bell
Franklin G. Bichlmeier
F. Calvin Bigler
L. Theil Bloom
David H. Clark
Louis M. Culp
Asher W. Dahl
Victor M. Eddy
Jimmie A. Gleason
Richard A. Gruendel
Donald W. Hatton
David A. Leitch
James A. Loeffler
Warren E. Meyer
Stephen F. Miller
Robert D. Parman

Eugene W. J. Pearce
Katherine Pennington
Lew W. Purinton
Lucien R. Pyle
Edwin D. Rathbun
Clifton C. Schopf
Alex Scott
Richard A. Siemens
Newton C. Smith
Arthur D. Snow, Jr.
G. Rex Stone
Wayne O. Wallace, Jr.
Roger D. Warren
Kermit G. Wedel
James Wilson
Emerson D. Yoder

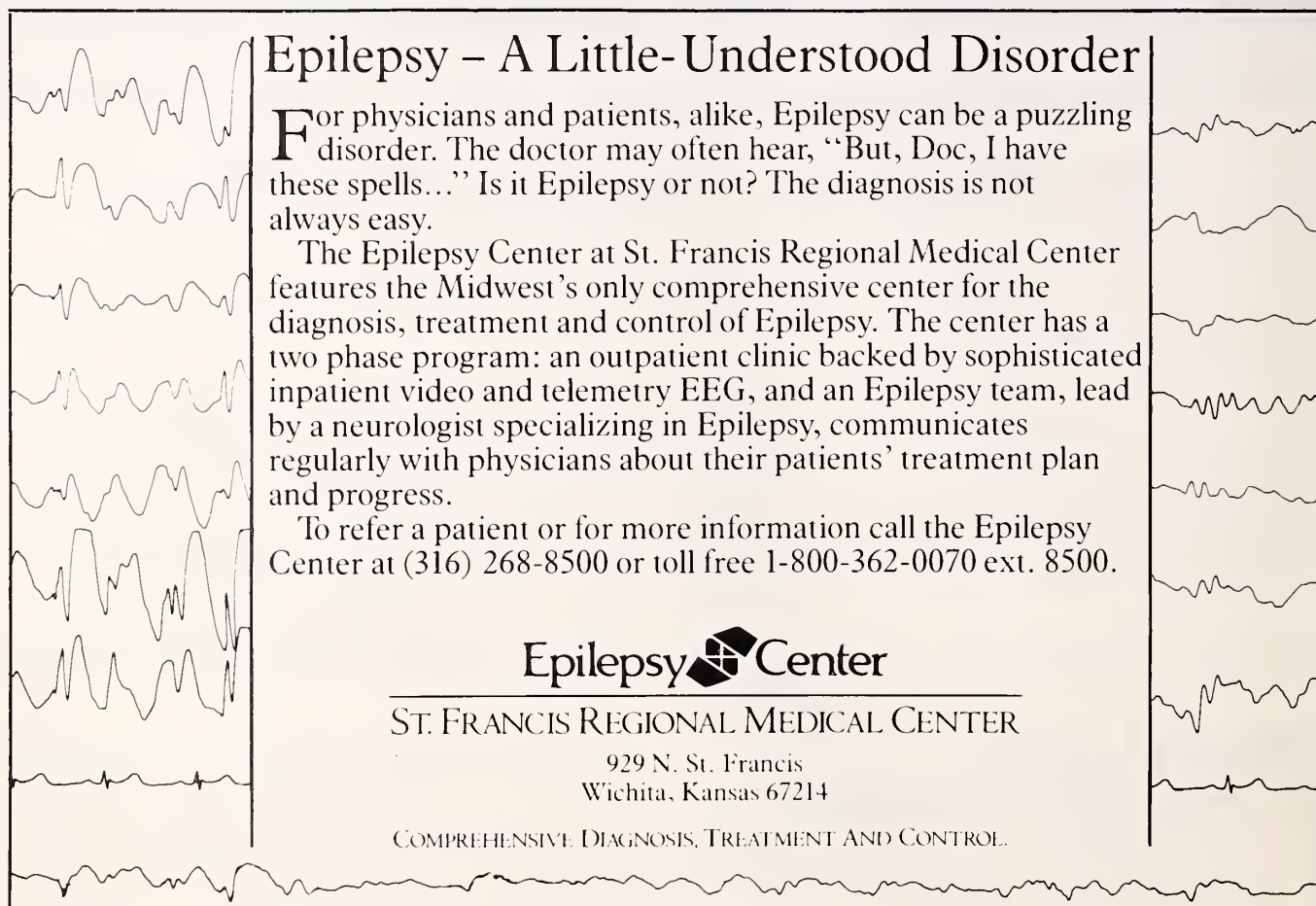
Also present was Mrs. Betty Glover, KMS Auxiliary President. Staff present were Val Braun, Gary Caruthers and Jerry Slaughter.

The **Minutes** of February 7, 1987 were approved. Considerable discussion was accorded the issues of **membership and the budget**. The declining numbers of membership and financial reserves will necessitate a significant dues increase soon, if the organization is to maintain its present level of activity.

The Attorney General has rendered an opinion concerning the **chiropractic "physician,"** stating that there is no basis for such a designation. KMS is urging the Board of Healing Arts to rescind their current interpretation which supports the term "chiropractic physician." Should the Board refuse to change their interpretation, it may take legal action to change the Board's position.

The Council heard an update on the following legislative issues:

- a. SB 113, optometric bill;
- b. SB 34 and SB 36, concerning the Board of Healing Arts;
- c. HB 2412, smoking regulation in public places;
- d. SB 35, prescription of drugs by PAs;
- e. HB 2418, technical inconsistencies in the tort reform legislation;
- f. Abortion issues dealing with reporting and parental consent;



Epilepsy – A Little-Understood Disorder

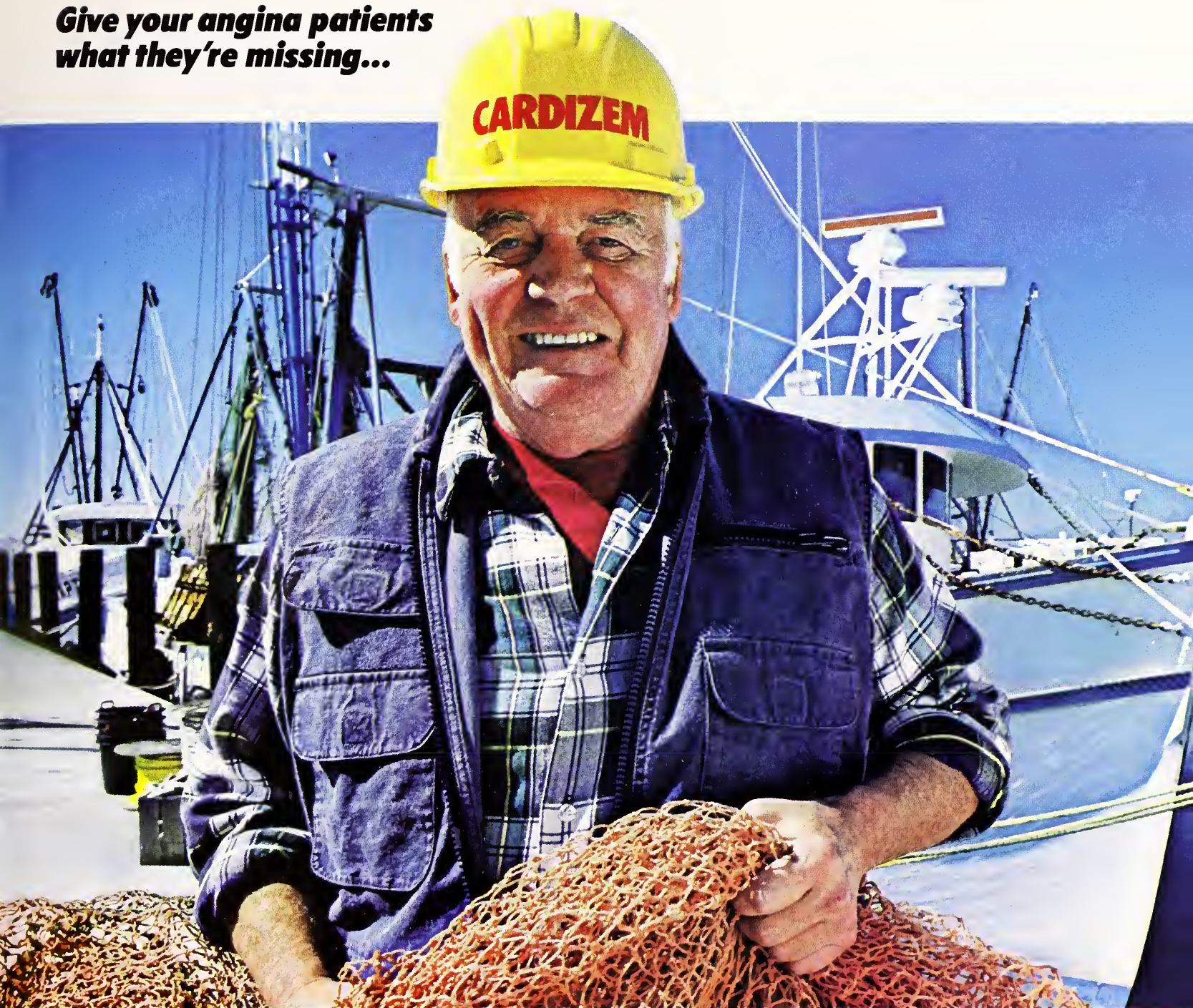
For physicians and patients, alike, Epilepsy can be a puzzling disorder. The doctor may often hear, "But, Doc, I have these spells..." Is it Epilepsy or not? The diagnosis is not always easy.

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**GREATER
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- **Antianginal action includes dilatation of coronary arteries, a decrease in vascular resistance/afterload, and a reduction in heart rate**
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***See Warnings and Precautions.**

Please see brief summary of prescribing information on the next page.



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Brief Summary Professional Use Information

CARDIZEM[®]

(diltiazem HCl)

30 mg, 60 mg, 90 mg, and 120 mg Tablets

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.

2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).

Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.

3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.

4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic

function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably asso-

ciated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:

Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.

Nervous System:

Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.

Gastrointestinal:

Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.

Dermatologic:

Petechiae, pruritus, photosensitivity, urticaria.

Other:

Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarthralgia, pain, polyuria, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 9/86

See complete Professional Use Information before prescribing.

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- g. SB 78, credentialing for professional counselors;
- h. SB 301, reporting of handicapped children;
- i. SB 19, anatomical gifts;
- j. HB 2186, establishing medical expert testimony fees for Workman's Compensation;
- k. HB 2589, trauma centers;
- l. SB 389, medical scholarships.

Jimmie A. Gleason, M.D., gave a detailed update on the **professional liability** situation and the Supreme Court review concerning the constitutionality of HB 2661.

Dr. Gleason and Kermit Wedel, M.D., reported on the results of the alternate delivery system feasibility study. They recommended, based on the study, that KMS not establish an HMO/FPA at this time. The Council accepted the report, and moved that there be no further KMS action in this regard at this time.

The Committee heard a detailed report concerning the **Impaired Physicians Program** and the agreement with the Board of Healing Arts. Ivan E. Rhodes, M.D., Chairman, was commended for the many years of dedicated service to the program as member and Chairman of the Committee. The

Councilors have agreed to assist the Committee in its duties, and will become members of the Committee.

Staff was directed to contact the SRS Department for clarification of exact localities and circumstances under which **obstetrical care** has reportedly been unavailable.

David A. Leitch, M.D., reported instances of local pharmacists filling only **partial prescriptions** for SRS clients, rather than as ordered by physicians. Staff was directed to relate this concern to SRS and to ascertain their policy in this regard.

Newton C. Smith, M.D., Chairman of the **Judicial Committee**, asked the Councilors to assist the Committee by monitoring the complaints referred to the local level for review and recommendation.

Roger D. Warren, M.D., Chairman, presented the **KaMPAC** report.

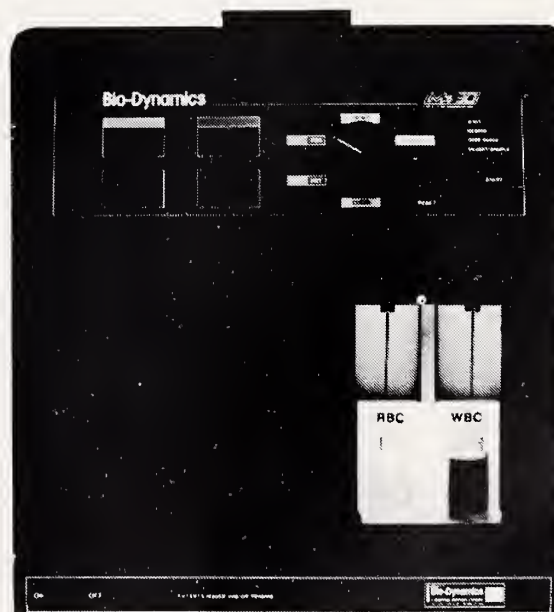
The Council heard a concern with **Oklahoma physicians** coming into Kansas to perform surgery, who are then required to pay back surcharge for professional liability insurance in Kansas.

The Council commended **Dr. Bichlmeier** for his year of leadership with a standing ovation. Dr. Bichlmeier responded by thanking all Councilors

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and the Executive Committee members for their good work.

The **next meeting** of the Council will be on May 3, 1987, at the Manhattan Holidome, at the conclusion of the Second House of Delegates meeting.

The meeting **adjourned** at Noon.

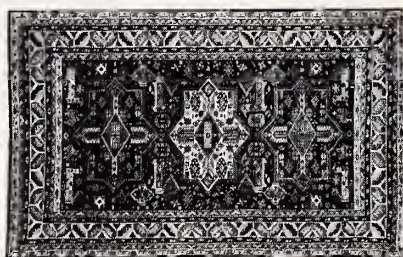
Report of the Meeting Held May 3, 1987

Donald W. Hatton, M.D., President, called the meeting to order at Noon on Sunday, May 3, 1987, at the Manhattan Holidome. Those present were Doctors:

Larry R. Anderson
Mark G. Bell
Norman W. Berkley
Franklin G. Bichlmeier
F. Calvin Bigler
L. Theil Bloom
Donald R. Brada
John P. Brockhouse
David H. Clark
Asher W. Dahl
Jimmie A. Gleason
Donald D. Goering
Richard A. Gruendel
Donald W. Hatton
David A. Leitch
Frank C. Lyons
Warren E. Meyer
Stephen F. Miller
Robert D. Parman

Eugene W. J. Pearce
Katherine Pennington
Terry L. Poling
Richard Preston
Lew W. Purinton
Ivan E. Rhodes
Clifton C. Schopf
Alex Scott
Richard Siemens
Arthur D. Snow, Jr.
Thomas F. Taylor
Don R. Tillotson
Linda D. Warren
Roger D. Warren
Wallace N. Weber
Kermit G. Wedel
James W. Wilson
Emerson D. Yoder

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Also present was Mrs. Phyllis Bigler, KMS Auxiliary President.

Also present was Bud Wright, Assistant Director, Division of Medical Society Relations, AMA.

Staff present were Val Braun and Jerry Slaughter.

The **Minutes** of the April 11, 1987 meeting were approved.

Jimmie A. Gleason, M.D., and Jerry Slaughter presented detailed reports and projections of the **professional liability** crisis.

The Council reviewed the House of Delegates' actions, particularly the reaffirmation of the **unified membership** with AMA. The consensus was that an educational process at the local level must be undertaken by Councilors and Delegates to explain to physicians the significance of belonging to organized medicine, and the benefits which such membership conveys.

The **KMS budget** and financial situation were reviewed and discussed in depth. KMS dues, at \$220, are among the lowest (47th) in the nation. The national average stands at \$322. The Council will consider 1988 dues at its September budget session, at which time a dues increase will be proposed. The Executive Committee was given the authority to proceed with the implementation of the following budget items: capital improvements project, professional staff salary upgrading, and filling the Public Affairs Director position. Other budget items will be prioritized and presented to the Council in September.

The following appointments to the **Editorial Board** were made with unanimous approval: reappointed to 3-year terms were Drs. Donald R. Pierce, David E. Gray and Howard N. Ward; new appointments to 3-year terms were Drs. Harry G. Kroll, James H. Ransom and Ralph R. Reed. James Gordon Price, M.D., Director, Department of Family Practice, was appointed as the UKSM-KC representative, replacing Jack Walker, M.D., the current Lieutenant Governor of Kansas. David E. Gray, M.D., was reappointed Editor.

The following schedule for **Annual Meetings** was announced:

1988 — April 28–May 1, Kansas City, MO, Alameda Plaza
1989 — May 4–7, Lawrence, Holidome
1990 — May 1–6, Colorado Springs, Broadmoor
1991 — May 2–5, Wichita, (not selected yet)
1992 — April 30–May 3, Salina, Holidome

The council directed that the State Meeting Committee solicit appropriate sites for the **1993 Annual Meeting**.

The Council considered the concerns with the unresponsiveness of the **UKSM-KC faculty** regarding organized medicine, and authorized a meet-



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- Hypersensitivity Bronchopulmonary Disease Profiles
- Immunoglobulin Assays
- Complement Profiles
- Immune Complex Assays
- Immune Deficiency Evaluations
- Sexually Transmitted Disease Serologies: AIDS, Syphilis, Hepatitis
- Drug Assays: Street & Therapeutic

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ing of KMS representatives with Chancellor Budig and D. Kay Clawson, M.D., Executive Vice Chancellor, UKSM-KC.

Dr. Hatton congratulated and introduced the following **newly elected officers**:

Terry L. Poling, M.D., Wichita, President Elect
Alex Scott, M.D., Junction City, First Vice President
Roger D. Warren, M.D., Hanover, Second Vice President
Katherine Pennington, M.D., Wichita, Constitutional Secretary
Donald R. Brada, M.D., Hutchinson, Treasurer
Ivan E. Rhodes, M.D., Wichita, Speaker
Warren E. Meyer, M.D., Wichita, AMA Delegate
John P. Brockhouse, M.D., Emporia, AMA Alternate
Jay S. Schukman, M.D., Great Bend, AMA Alternate
Mrs. Phyllis Bigler, Garden City, KMS Auxiliary President

Dr. Hatton stated that he intends to involve the Auxiliary in the Governor's Task Force on **AIDS**, of which he is Co-Chairman.

Dr. Hatton introduced Bud Wright, AMA Division of Medical Society Relations, and thanked him for participating in this annual session.

The **next meeting** of the Council has been scheduled for Saturday, September 19, 1987, at 10:00 a.m. at the Topeka Holidome.

The meeting **adjourned** at 1:20 p.m.



AUXILIARY NEWS

Am I Just A Pretty Face?

Oh, am I just a pretty face?
Or does he like Chantilly lace?
Sometimes he seems so far away
He scarcely hears a word I say.
His mind is lost in reverie,
Our time is such monotony.

He gives me money, children, hope.
Some days it's really hard to cope.
I think, I hope, he really cares.
Who knows what thoughts behind the stares —
The sick child, the bacteria,
Or, could it be — porphyria?

What bothers him, oh, who can know?
He worries much, he's troubled so.
About my friends I never ask;
If they're sick he'll say that's *his* task.
Matters of health he'll not confide,
He'll turn the talk away, aside.

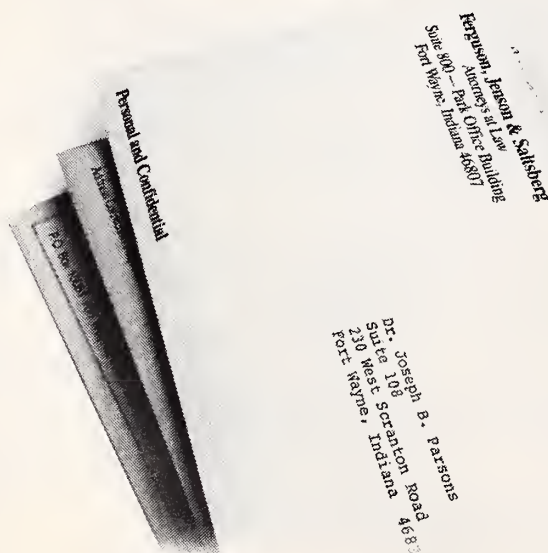
At times I think he's such a bore!
What are husbands of docs' wives for?
I work so hard, he never sees
His wife who always tries to please.
He says that I'm his best, best friend
And that is where the talk may end.

He never lets me see the sick;
I do my best to make him tick.
I raise his kids, buy all his cars,
Launder his clothes, help fight his wars,
Love him a lot, curtail his wealth;
Who can say I don't help with health?

It's hard to be a doctor's wife,
It's a strange, funny sort of life.
There aren't a lot of simple rules,
There are no medical wives' schools.
I'm glad my doc turned out to be
Someone who can put up with me.

Phyllis Bigler
KMSA President

Crisis in black and white.



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Someday it may be you against a negligence charge. When that day comes and your professional reputation is on the line, you're going to want all the help you can get. To make sure you have it, contact your Medical Protective General Agent today.

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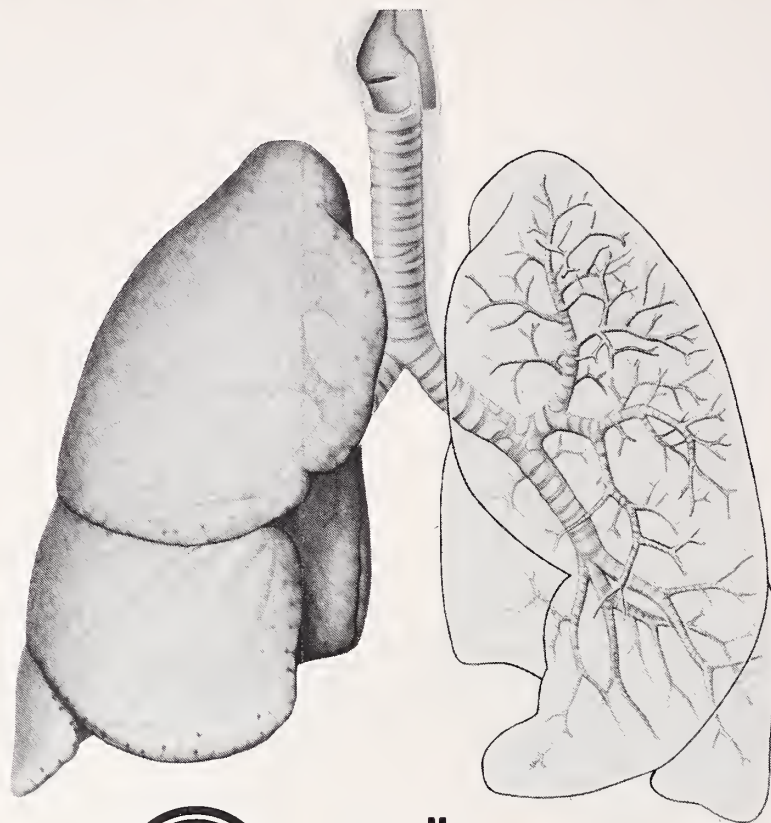


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Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication:
Known allergy to cephalosporins.

Warnings:

CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness,

insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.

- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinistest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

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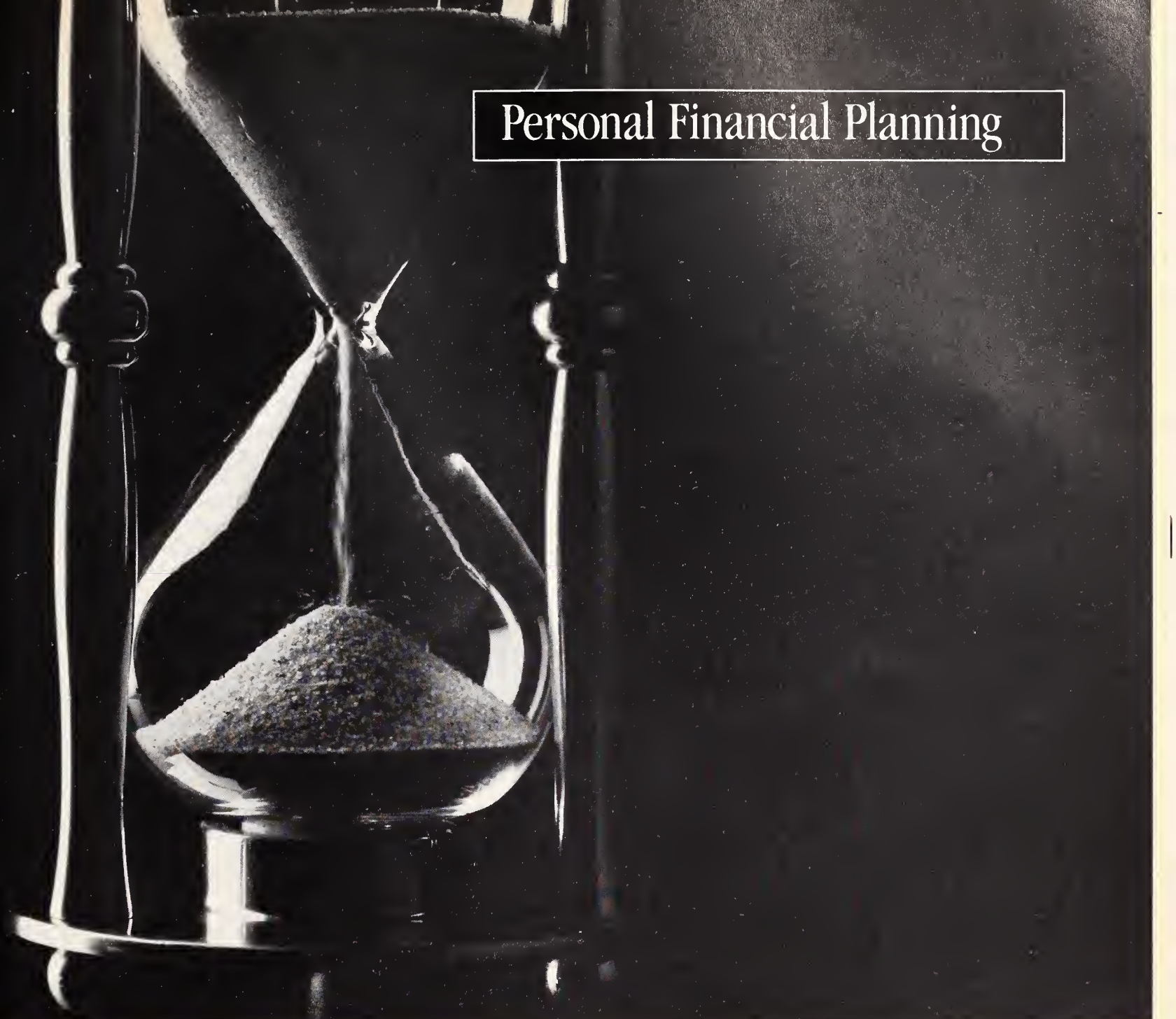
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Brief, concise **articles** are preferred; an ideal manuscript will not exceed five double spaced pages. All material will be edited by the staff copy editor to assure clarity, good grammar and appropriate language, and to conform to KANSAS MEDICINE style and format. When feasible, material may be condensed.

The **author** will be asked to review the galley proof prior to publication to verify statements of fact. Although editing and proof-reading will be done with care, the author is responsible for accuracy of material published.

The **galley proof** is for correction of ERRORS; rewriting of material must be done prior to submission. Authors are urged to carefully check manuscripts and galley proof for errors that could result in inaccurate information.

Drugs should be referred to by generic names; trade names may follow in parentheses if useful. All **units of measure** must be given in the metric system.

KANSAS MEDICINE will print a maximum of ten **references**. All applicable references should be marked by superscripts in the text in the order cited. If more than ten sources are cited, the author should designate the ten most significant to be printed, and readers will be referred to the author for the complete list.

Illustrative material must be identified by its referral number in the text and be accompanied by a short legend. **Photos** should be black and white glossy prints. **Tables** should be self-explanatory and should supplement, not duplicate, the text.

KANSAS MEDICINE will assume the cost of B/W engravings, cuts, and tables for two units. A unit is defined as 1/4 page. The author(s) will be billed for additional units at a cost.

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SPECIAL FEATURE

Malpractice '87: Status and Solutions

M. MARTIN HALLEY, M.D., J.D.,* *Topeka*

This is the first of two articles which provide an updating of the malpractice situation to its current state. The first part includes an overview of local and national experience and legislation with particular emphasis on the conditions in Kansas.

ABSTRACT: *Although the atmosphere of crisis appears to have abated in most states except Florida, indications of further troubles persist in the increasing frequency and severity of medical malpractice claims; the decreasing availability, affordability, or adequacy of insurance coverage; and the possibility of further unfavorable court decisions involving recent reform legislation. The direct causes of current insurance problems appear to be unanticipated changes in the assessment of tort liability and damages, and the resulting uncertainty attending these changes. There are no data to substantiate allegations that "bad doctors" or improper practices by the insurance industry are primary causes. Statutory reforms, sometimes characterized as "piecemeal," have been enacted by many states, and interest in possible legislation continues at the federal level.*

In Kansas, the comprehensive medical malpractice legislation of 1986 included a limitation of \$1,000,000 on total awards and reduced insurance coverage from the Health Care Stabilization Fund to \$1,000,000 per claim. The 1986 legislation is presently undergoing legal challenge, and the previously enacted collateral source statute has been declared unconstitutional by the Kansas Supreme Court. Personal liability may result for some Kansas physicians if the cap on awards is struck down, since private excess coverage is not available to all.

A final solution is not yet available, but quality assurance and tort reform should continue to be supported, since the former is essential and the latter has demonstrated some beneficial results. The long-term effects of tort reform, however, are uncertain, and alternative solutions should continue to be evaluated — including methods for administrative compensation as in the model statute for medical accident compensation discussed below.

Medical professional liability continues to be troubled by steadily increasing claim frequency and severity, and the resulting problems of insurance affordability, availability, or adequacy of coverage. Two crises threatening to disrupt health care delivery have occurred in recent years. The response to each has been legislation at the state level, where statutes have been passed, and others proposed, dealing with tort reform, insurance practice, and quality assurance. The crisis of the mid-1970s subsided as insurance again became available, although the statutes have been termed "piecemeal legislation," and the actual significance of tort reforms may have been apparent rather than real. The crisis of the 1980s also appears to have subsided in most states following a second round of reform legislation, accompanied by considerable popular support as similar liability insurance problems occurred in sectors other than health care. The potential for recurrent crises continues, however, as in Florida, in the persisting basic causes and unfavorable appellate court decisions.

This communication provides a perspective of the present problem and discusses attempted and proposed solutions.

Trends in Claims and Awards

The upward trend in frequency and severity for both claims and awards is continuing. Nationwide, claim frequency appears to be increasing at an annual rate of 10 to 15 percent, and it appears that presently one of five physicians can expect a suit each year. Claim severity similarly is continuing its upward progression. Even in Canada, where in past years low frequency of malpractice suits and relatively low premiums have been the rule, the trend has been reversed with increasing frequency, several awards in excess of a million dollars, and increasing insurance premiums.

Nationally, the American College of Obstetrics

* 901 Garfield, Topeka, KS 66606.

and Gynecology reported that 73 percent of its 24,500 members have been sued at least once for malpractice, and that in New York one half of all obstetricians have been sued three or more times. In Kansas, a state medical society survey (1,261 responses, representing about one-half of the active, practicing membership) indicated that 40 percent of physicians had been sued once, one-third had two to four suits, and fewer than 1 percent had five or more claims. Frequency of suits varied by specialty, with physicians in high-risk practices experiencing greater claim activity. A Shawnee County Medical Society survey (235 members, 144 responses) revealed that 70 lawsuits had been filed against members since 1972, 59 percent within the last five years. Eighty-four percent of the lawsuits involved board-certified specialties. None of the surveys implicated marginal practitioners as a significant factor.

These trends and data emphasize the magnitude of the problem and provide some evidence to contradict an increasingly common misrepresentation, that "bad doctors" are a primary cause. This allegation is not supported by data and is generally known to be untrue, but it is nevertheless appearing with increasing frequency from diverse sources, usually in association with or in opposition to professional liability reforms. It is surprisingly difficult to rebut, due to the lack of adequate data, and appears to be diverting attention from real causation.

Several responsive trends affecting cost and access are also occurring. Physicians and surgeons appear increasingly concerned about legal consequences and are more often considering such consequences in patient care or treatment decisions. Some are more cautious in accepting cases involving legal risk, and others no longer accept high-risk cases. Many order more diagnostic tests, obtain more consultations, and hospitalize more frequently or longer. Higher charges are reported in view of legal risks, additional time requirements occasioned by these risks, and the requirement of more extensive records. Some specialists have ceased obstetrical practice, and instances of early retirement continue to be reported.

Insurance

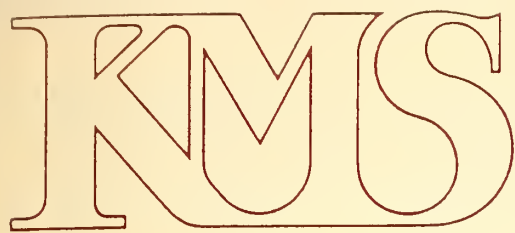
Premium increases with continued availability in a tight "seller's" market precipitated the crisis of 1984-85 in medical liability insurance. There appears to have been a reduction in the number of companies writing this insurance, as well as in the coverage offered. The remaining companies are highly selective in their underwriting activities and

are continuing to replace occurrence policies with claims-made policies. Premiums have continued to increase, or have stabilized at higher levels, but actual coverage has diminished, due to mechanisms such as higher deductibles, more exclusions, less coverage, or additional policy limitations. The cost of insurance to the purchaser has thus increased beyond the growth of premiums to the extent of these factors, which stabilize availability and affordability through reduction in the amount and adequacy of coverage. Similar trends have been noted in other types of liability insurance, reaching beyond the medical area into other lines, including products, industry, private and governmental organizations, boards of directors, municipalities, and other entities concerned with risk and compensation.

Severe health care insurance problems appeared to be unevenly distributed and were particularly severe in a small number of states (California, Florida, Illinois, Massachusetts, Michigan, New York), and for a few medical specialties (obstetrics-gynecology, orthopedics, neurosurgery). Many physicians have, therefore, not yet experienced dramatic increases in their professional liability premiums. While premiums in the high-risk specialties are reported as ranging up to \$100,000 or higher, the premiums paid by other practitioners may be considerably lower. Average insurance premiums as percentage of gross physician income range from 2.7 percent in Ohio to 10.4 percent in New York, where reported premiums were 23.5 percent of gross for obstetricians, 13.9 percent of gross for combined surgical specialties, as compared with the estimated national average of 3-4 percent.

There is no evidence at present to support another frequently encountered misconception of the professional liability problem, that fundamental causation involves primarily insurance industry practices such as anticompetitive pricing, imprudent business practices, declines in investment income, or restriction by state insurance regulation. In contrast, both theoretical economic analysis and other evidence support the conclusion that unanticipated changes in the manner in which tort liability has been established and damages assessed, along with the uncertainty engendered by these changes, are directly responsible for the current affordability and availability problems in property-casualty insurance.

Current information indicates that the insurance crisis is easing nationally for most lines. However, previously experienced unfavorable loss ratios in medical malpractice appear to be continuing, the number of companies writing this insurance appears



KANSAS MEDICAL SOCIETY

Newsletter

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SEPTEMBER 1987

AMA OPINION SURVEY RESULTS

The AMA has released the results of its 1987 physician and public opinion surveys on health care issues. The physician survey, in which 1,000 doctors were interviewed, revealed that 26 percent see the cost of medical care as the main problem facing medicine today. Eighteen percent believe professional liability is the major problem, and 13 percent believe the number-one problem is government regulation.

AIDS was considered a "very serious" national health problem by 75 percent of the physicians surveyed. However, 78 percent believe children with AIDS should be allowed to attend regular school classes.

According to public opinion, measured by the survey, the main problems facing medicine are cost, 67 percent; and quality, 16 percent. Seventy-six percent said they receive routine medical care in a private physician's office.

Some notable public attitudes about doctors are as follows: 63 percent believe most doctors take a genuine interest in their patients, and 61 percent believe doctors are usually up-to-date on the latest advances in medicine. However, only 45 percent said physicians usually explain things well to their patients. Additionally, 56 percent of those surveyed believe doctors are too interested in making money; 58 percent said physicians are too quick to prescribe drugs when other kinds of treatment might be useful; and 69 percent said doctors keep patients waiting too long.

On the subject of AIDS, 87 percent of the patients surveyed feel the disease is a very serious national health problem. Fifty-seven percent believe children with AIDS should be allowed to attend regular school classes, and 57 percent believe employees with AIDS should be allowed to continue working.

KMS PROFESSIONAL REVIEW SERVICE

The Kansas Medical Society Professional Review Service offers peer review services to hospitals and institutions that are in need of objective and confidential medical opinions regarding competency matters involving individual staff members. The service is intended to provide hospitals with an acceptable alternative when the handling of questions of staff privileges becomes difficult because of local considerations, small staff size or other reasons.

In This Issue...

- AMA survey results
- KMS professional review service
- Mandatory Medicare assignment in RI
- No-Smoking statute
- Ritalin abuse
- Survey of older Kansans
- Medical education seminars
- Reorganization at WSU
- Congratulations, Ann Rempel
- Athletic injuries book
- Kansas Habits, Kansas Hopes
- KMS workshops

All reviews are kept in strict confidence. The opinions rendered by medical consultants are their own, and neither imply nor reflect the approval or disapproval of the Kansas Medical Society. Every effort is made to complete the review within 60 days.

For information about the service, please contact Val Braun, Associate Executive Director, The Kansas Medical Society, 1300 Topeka Avenue, Topeka 66612, phone (913) 235-2383, WATS (800) 332-0156.

The following are needed to perform the review:

- Name of the contact person and facility seeking review;
- Records to be reviewed (depending on the volume and nature of records, travel to the site may be required);
- Specialty of the physician(s) being reviewed.

The transaction is handled through KMS Services, Inc., a Kansas Medical Society subsidiary. Flexible payment arrangements can be made, based on a flat-fee or hourly basis.

MANDATORY MEDICARE ASSIGNMENT APPROVED IN RHODE ISLAND

Rhode Island has joined Massachusetts and Vermont as the third state legislating some version of mandatory assignment under Medicare. In Rhode Island, however, mandated assignment provisions will be restricted to individuals and families having very low incomes.

Physicians will be required to accept the Medicare-determined amount as payment in full for those patients who present a card indicating their eligibility for the state's pharmaceutical assistance program for the elderly. Annual income levels established for the program are \$12,000 for individuals and \$15,000 for married couples. Failure of physicians to accept Medicare's "reasonable charge" will constitute unprofessional conduct under the state's medical discipline act.

The legislation is now awaiting the governor's signature. The legislature's intent is for the law to be effective for one year. Starting early next year, a 21-member study commission will look into all matters relating to mandatory assignment.

Physicians in a fourth state, Connecticut, averted mandatory assignment when the legislature statutorily recognized the state medical society's voluntary Courtesy Card Program for low-income individuals and families.

NO-SMOKING STATUTE NUMBER 21-4008

Due to the large number of inquiries, the State Office of the Revisor of Statutes has assigned a statute number to the recently passed no-smoking legislation. The main section of that law will be located at K.S.A. 21-4010. Physicians wishing to cite this statute on their no-smoking signs may use this citation. KMS Services, Inc. is developing attractive no-smoking signs that may be purchased for use in offices. Details will be sent to all members announcing the availability of the signs.

RITALIN ABUSE

The Medical Society of Sedgwick County has notified KMS that an individual in Wichita has obtained his EEG report and changed it from normal to abnormal. This person is taking the report to area doctors in an attempt to obtain Ritalin. Since the person may begin to see physicians elsewhere once his local supplies are exhausted, doctors throughout the state are requested to report any similar experiences to Dwight Allen, Executive Director of the Sedgwick County Society, (316) 683-7557.

SURVEY EXAMINES STATUS OF OLDER KANSANS

For the first time in history, there are more Americans over 65 than there are teenagers. Every day more than 5,000 Americans turn 65, reports Blue Cross and Blue Shield of Kansas, which recently completed a telephone survey of Kansans in this age group.

The survey was based on responses from people who were living at home, in an apartment or a private household, and comprised 1,000 Kansans, 67% age 65 and over, 33% in the 55 to 64 age group. Responses were grouped in four areas: marital status, health, finances and insurance. They suggest that Kansans 65 years and over will be moving from:

1. Being in a relatively good financial condition to generally struggling financially;
2. Being a population with close to an equal number of males and females to a population with a majority of females;
3. Being characterized by married couples to being characterized by single women;
4. Being a group which sees itself as generally in good health to being a group which sees itself as being in poor health;
5. Making fewer to making more visits to the doctor's office;
6. Experiencing fewer overnight stays in the hospital to experiencing more overnight stays.

For a detailed report of the survey, contact Carla Deckert at (913) 295-5203.

MEDICAL EDUCATION SEMINARS

The Johnson and Wyandotte county medical societies, together with Shawnee Mission Medical Center, Humana Hospital and KMS, are sponsoring a dinner meeting and program entitled "The Malpractice Fix," to be held on Tuesday, October 27, 1987 at the Doubletree Hotel in Overland Park from 5:30 to 9:00 p.m. John Young, M.D., will speak on "The Malpractice Fix in Kansas," and Jeffrey O'Connell, J.D., will discuss "How We Got into the Fix" and "How to Get Out of the Fix." Physicians attending will earn 2 hours of CME credits. Information and reservations may be obtained from Mrs. Alliene Bennett, (913) 432-9444.

The Kansas Medical Assistants Society will hold its fall education seminar, "Chronic Diseases--Role of the Medical Assistant," on Saturday and Sunday, October 24 and 25, at the Park Inn International in Topeka. CEUs have been applied for. Participating in the seminar are Doctors C. Michael West; Thomas E. Scott; Joseph M. Stein; and Karl K. Kavel, all of Topeka. Linda E. Stout, R.N., will also participate. More information may be obtained from Karla Hatfield at (913) 233-1710.

REORGANIZATION AT WSU

The Kansas Board of Regents has approved the reorganization of the College of Health Professions at the Wichita State University. The reorganization groups some of the programs to form single departments and adds the University Gerontology Center to the College. Also, the medical technology and respiratory therapy programs have been grouped into the Department of Clinical Services.

The new Department of Health, Administration and Gerontology was formed to oversee programs in health care administration and in gerontology, as well as interdisciplinary undergraduate and graduate programs in health science. This department also will administer the medical records program offered in cooperation with the University of Kansas.

For more information on the reorganization, contact Dean M. Diane Roberts, (316) 689-3600.

CONGRATULATIONS!

Ann Rempel (Mrs. John), of Wichita, is the newly elected Director of the AMA Auxiliary North Central Region. She also serves on the AMAA Bylaws Committee. A dedicated Auxilian, Mrs. Rempel was KMSA president in 1984-85.

ATHLETIC INJURIES BOOK

The Kansas Association for School Health has published a book, Prevention and Management of Injuries Incurred in School Activities. Written for school administrators, faculty and members of the medical profession, the book contains sections on examination, prevention and treatment, plus a glossary and exhibits. To encourage dissemination of the information it contains, the book is not copyrighted, and duplication is encouraged. KMS contributed financially to the development of this book and also reviewed and approved the Optional Physical Examination Form in the examination section.

KANSAS HABITS, KANSAS HOPES

The Kansas Citizens' Forum is sponsoring a call for papers to be used in Kansas Habits, Kansas Hopes, a statewide "conversation" about the quality of life, economic development and future of Kansas. Some papers will be read at a conference December 11 and 12 in Topeka; some will be published in the conference proceedings or in articles in state newspapers. To contribute a paper, authors must first submit a proposal of up to 250 words, due by October 17. For information and project reference materials, visit a library or contact Larry Hedges, Director, Kansas Citizens' Forum, P.O. Box 1696, Topeka, 66601, telephone (913) 232-3285.

KMS WORKSHOPS

Medical office management workshops sponsored by KMS will be given on October 14 and 15. The \$50 fee for each is payable to KMS Services, Inc. More information may be obtained by calling (800) 332-0156. Workshop topics and places follow:
Oct. 14, 8:30 a.m. Medical Office Personnel Management
Oct. 14, 1:30 p.m. Marketing and Promoting a Medical Practice
Oct. 15, 8:30 a.m. Telephone Collecting
Oct. 15, 1:30 p.m. Computers in Medical Practice

still to be declining, and excess coverage for individuals or reinsurance for carriers is not yet readily available.

Appellate Court Decisions

The present climate appears to favor reform of tort law, as reflected in some court decisions upholding reform legislation, but the issues are still in doubt in other jurisdictions. An increasing number of decisions can be anticipated as challenges to recently enacted tort reforms are filed.

In a bellwether decision, which may be persuasive in other states, the *California Supreme Court* upheld the Medical Injury Compensation Reform Act (MICRA), several years after passage by the legislature, in respect to its critical elements: a \$250,000 limit on general damages, disclosure of collateral sources, periodic payment of future damages, and structured limitation of attorney's fees. The *Supreme Court of Illinois* upheld sections of the Illinois Tort Reform Act dealing with collateral source, periodic payments, limitation of contingent fees, and elimination of punitive damages.

A *Louisiana district court*, on March 30, 1987, held constitutional the Louisiana Medical Malpractice Act, including a \$500,000 limitation on medical liability awards. An appeal to the Louisiana State Supreme Court is expected. In contrast, however, the *Florida Supreme Court*, on April 23, 1987, declared unconstitutional the cap of \$450,000 on non-economic damages, defined as compensation for pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, and other non-monetary harms. The court upheld other provisions of Florida's 1986 Tort and Insurance Reform Act, including greater regulation of insurance rates and modification of joint and several liability. The *Kansas Supreme Court*, on July 17, 1987, struck down as unconstitutional the collateral source statute of 1985 (K.S.A. 60-3403), on the basis of the equal protection clause of the Bill of Rights of the Kansas Constitution. Legal challenge of the 1986 comprehensive malpractice legislation, including the cap on awards, is currently pending at the district court level.

State Legislation

During the crisis of the 1970s, more than 300 statutes were passed by the fifty states, and insurance again became available. As a result of the crisis of the 1980s, more than 1,000 bills were proposed in state legislatures, making some changes in tort law, attempting to regulate contingent fees, proposing restrictions or requirements on insurers, addressing

the problem of joint and several liability, and imposing new requirements on medical practice.

A significant trend has been the modification of tort law for civil actions generally, not just for medical liability. At least 32 states have passed some type of tort reform in recent months. Eighteen states applied their tort reforms to all civil actions. At least 13 states passed limits on non-economic damages. Seven of these applied the law to all civil cases. The legislative struggles have been marked by considerable support from coalitions outside health care, all with problems relating to liability insurance.

Other tort reform legislation by states was as follows: 21 states enacted reforms limiting the size of malpractice awards, raising the total number of states that have such restrictions to 29; 10 states enacted collateral source legislation, making a total of 23 states that have enacted this reform; 12 states enacted legislation to reduce the statute of limitations for cases involving minors, making a total of 25 states that have implemented this reform; 10 states have limited attorney fees or have implemented sliding scales; 25 states have established pretrial panels to screen malpractice allegations; 17 states have modified or eliminated their laws on joint and several liability; 18 states have established penalties for individuals who file frivolous lawsuits, requiring unsuccessful plaintiffs to pay defense costs; and 1 state has established a no-fault compensation law for brain-damaged babies, covering injury to the brain and spinal cord caused by oxygen deprivation or mechanical injury in the course of labor, delivery, or resuscitation in the immediate post-delivery period.

The 1986 Kansas Medical Malpractice Reform Act (K.S.A. 1986 Supp., table of sections L. 1986. Ch. 229, Constitutions Volume) should be noted as an example of comprehensive medical malpractice legislation. It addresses essentially all major areas of tort reform, when viewed together with the 1985 legislation limiting the collateral source rule (K.S.A. 60-3403, recently declared unconstitutional) and limiting the amount of punitive damages (K.S.A. 60-3402). The statutes of limitations for health care providers were amended in 1976, with limits of two years, to a maximum of four years beyond the time of the act for the rendering of or failure to render professional services (K.S.A. 60-513), four years from the last occurrence for radiation injury (K.S.A. 60-513b), and eight years after the act for minors and other persons under legal disability (K.S.A. 60-515).

The principal reform provisions of the new leg-

isolation are a \$1,000,000 cap on total awards, and a sub-cap of \$250,000 on non-economic damages (K.S.A. 60-3407), with a "pinhole" provision for supplemental medical care and related benefits up to a total possible award of \$3,000,000 (K.S.A. 60-3411). *Additional tort reforms of the law are:* the admissibility of screening panel findings and the ability to subpoena panel members as witnesses at trial (K.S.A. 65-4904); itemization of verdicts to indicate economic and non-economic loss (K.S.A. 60-3408); structured awards through the purchase of annuity contracts (K.S.A. 60-3409); stricter expert witness qualification, requiring an expert to have devoted at least 50 percent of his professional time within the preceding two years to the same profession in which the defendant is licensed (K.S.A. 60-3412); mandatory settlement conferences within 30 days before trial (K.S.A. 60-3413); and approval of attorney fees by the judge after an evidentiary hearing (K.S.A. 7-121b).

Insurance provisions of the new law include the requirement for basic insurance coverage of \$200,000 per claim, \$600,000 annual aggregate (K.S.A. 40-3402); reduction of insurance coverage under the Health Care Stabilization Fund to \$1,000,000 per claim, \$3,000,000 annual aggregate

(K.S.A. 40-3403); requirement of equivalent insurance coverage if Fund coverage is terminated (K.S.A. 40-3403a); experience rating for surcharge amount (K.S.A. 40-3404a); and a requirement for insurers to report claims to the provider regulatory agency and to the department of insurance (K.S.A. 40-3421).

Provisions for quality assurance include a number of sections expanding the powers of the Board of Healing Arts, such as provisions for proceeding against licensees (K.S.A. 65-2836), definitions of incompetency or unprofessional conduct (K.S.A. 65-2837), disciplinary action against licensees (K.S.A. 65-2838), and provisions for administrative fines (K.S.A. 65-2863a). Other sections include mandatory risk management for medical care facilities (K.S.A. 65-4922); denial, suspension or revocation of a medical facility license for failure to report or failure to maintain a risk management program (K.S.A. 65-430); mandatory reporting requirements for certain substandard acts (K.S.A. 65-4923); reporting and procedures for impaired providers (K.S.A. 65-4924); confidentiality of reports, records and proceedings (K.S.A. 65-4925); and immunity from civil liability for report or investigation (K.S.A. 65-4926).

Concerns arise from the reduction of Fund insurance coverage to \$1,000,000 per claim, at a time when private excess liability insurance above this level is not available other than from a single company that is currently accepting no new clients. As a result, a considerable number of Kansas physicians may be exposed to personal liability if the cap on awards is struck down, as has already occurred with the 1985 collateral source legislation. Other concerns arise from the possible applications of the reporting requirements, which impose an affirmative duty upon health care providers, or medical care facility agents or employees, subject to disciplinary or criminal penalties for intentional or willful violation, to report any act that a health care provider may have committed which is or may be below the applicable standard of care or may constitute grounds for disciplinary action.

The second half of Dr. Halley's article will appear in the October issue of KANSAS MEDICINE. It will consider activity on the federal level, examine alternative solutions, and offer pertinent conclusions. A bibliography will accompany that portion.



**OMAHA MID-WEST
CLINICAL SOCIETY**

**55TH ANNUAL
POSTGRADUATE ASSEMBLY**

OCTOBER 26, 27 AND 28, 1987

**RED LION INN
OMAHA, NEBRASKA**

FOR INFORMATION CONTACT

**Lorraine Seibel
Omaha Mid-West Clinical Society
7363 Pacific Street, Suite 205-B
Omaha, Nebraska 68114
(402) 397-1443**

How to Avoid the 'Failure to Diagnose' Claim*

THE BAD NEWS IS: One of every physician's greatest risks of being sued is for a "Failure to Diagnose" allegation.

THE GOOD NEWS IS: Implementation of some simple safeguards can substantially reduce your risk of suit for "Failure to Diagnose" claims.

The reports of malpractice cases tend to zero in on the bad results/specific damage to the patient — without identifying system safeguards which could have protected the physician from suit. This **LOSS PREVENTION LETTER** will concentrate on what can be done to avoid and defend "Failure to Diagnose" claims.

Many "Failure to Diagnose" cases originate in the outpatient environment. Physicians need to be aware that large malpractice awards in "Failure to Diagnose" cases have resulted when the patient was seen **ONLY ONE TIME BY THE PHYSICIAN INVOLVED**. In some cases, the patient was not even seen for the condition for which he/she later sued. Consider a Texas case:

The patient saw the physician for cough and chest pain. The physician saw a mole-like growth on her arm but did not identify it, perform a biopsy or warn the patient. Another doctor diagnosed melanoma three months later. At surgery, lymph node resection was negative for metastasis and the patient recovered uneventfully. She sued the first doctor for failure to diagnose the potentially fatal disease. The surgeon testified that delay in diagnosis did not change the mode of treatment; and since no metastasis was found, her life span had not been shortened. At the first trial, the district court gave summary judgment in favor of the physician. The appeals court overturned the decision. They decided the malignancy must have grown in the three-month interval, "at least by some imperceptible amount" and that the growth of a deadly malignancy constitutes an injury. This places short-term and outpatient care providers at a special risk.

Problems and Solutions:

Based upon our experience and review of a va-

*Reprinted by permission of *Loss Prevention Letter*, March 1986. For subscription information write to: Practice and Liability Management Consultants, 1600 Mary Drive, Pleasant Hill, CA 94523, (415) 686-4800.

This article is not intended to provide legal advice, and no attempt is made to define conduct which would have been appropriate in particular cases to meet acceptable standards of care.

riety of "Failure to Diagnose" claims, the following recommendations can help protect the physician from risk. Breast cancer is used as an example, although the principles are applicable to all types of "Failure to Diagnose" cases.

Example: Breast Cancer Claims

Any "Failure to Diagnose" cancer case is more difficult to defend because the American Cancer Society stresses that early diagnosis can result in cure. Defense attorneys tell us this is a difficult position to discredit in a juror's mind. Therefore, any delay in diagnosis which can be attributed to the actions or inactions of the physician can make the defense difficult.

PREVENTABLE PROBLEMS in "Failure to Diagnose" cases are:

1. *Lack of Documentation:* The most common problem is the failure to fully describe the breast lump in the medical record. A note which says "Mass, left breast" is an automatic two strikes against you should the patient at any time in the future develop cancer in the left breast. It does not matter whether or not the cancerous lump was the same lump that you originally examined because your records can't prove it wasn't. The patient will testify that it was the same lump you examined! The record of any mass should include the length of time it has been present, the location, size, consistency, degree of tenderness, whether it is fixed, and any other information which clearly identifies the mass. The plan for follow-up or further treatment should also be documented.

2. *Failure to Follow-up:* Would you like to be the defendant in the following case? The records show that a patient's breast mass was first noted five years ago. The family history documents the patient's mother and sister have had breast cancer. Notes in the record say the patient should have a mammogram or a consultation with a surgeon. The patient is seen by multiple physicians within the group frequently over the course of the next five years. No chart note during that period mentions the results of the mammogram, the surgical consultation, or any subsequent breast exam. This patient, like so many "Failure to Diagnose" cases fell through the cracks within the group's procedural and record keeping systems.

3. *Eliminate Cracks in the System:*

- A. Review Your Notes: One simple, very basic

prevention step is to always review the note of the patient's last visit. Check to see if there was a symptom which should be re-evaluated at this visit. A patient, particularly a patient who fears cancer, may psychologically depend upon you to bring up the topic again. The patient may think that since you know about the lump, if it was important you'd check it again! Yes, that can be contributory negligence on the part of the patient, but it won't eliminate your liability.

B. Maintain a Problem List: A Problem List which lists all unresolved problems can be particularly useful in avoiding a "Failure to Diagnose" case when the patient is frequently seen. A note to "recheck the breast in 6 months" can get lost in the multitude of progress notes generated for other conditions in the interim.

C. Establish Follow-up Safeguards: If you send a patient out for a test or a consultation, have a system which confirms that the test or consult was done; and what results were found. A simple system for tracking consultations is to use a three copy form which provides a tickler copy for your file, a copy for the consultant's file, and a final copy back to your records. Another easy system to track results is to review and initial all reports before they are filed in the patient's medical record. You will also want to establish a "tickler system" for notifying the patient of abnormal results and the need for further treatment or follow-up.

D. Educate the Patient: Make the patient aware of the importance of follow-up. Give instructions to the patient which clarify the symptoms which require follow-up prior to the next scheduled recheck (i.e. increase in size of lump, etc.).

Consider the Worst Diagnosis:

Many "Failure to Diagnose" cases involve serious disease processes which have some symptoms similar to common ailments. The physician most frequently gets in trouble when he/she diagnoses the usual minor condition and it was the more serious one this time. Is it indigestion, or is it a myocardial infarction? To a degree, you can minimize your risk of a "Failure to Diagnose" case if your records clearly document that you considered all alternatives. It is easier to defend a case where the Differential Diagnosis says: "Rule out Myocardial Infarction, Probable Indigestion" than it is where the only diagnosis the physician seems to have considered was "Indigestion." The negatives recorded in a physical examination can also provide protection for you. "Pain does not radiate" is a greater protection than "negative" recorded under symptoms.

Telephone Diagnosis:

Many physicians who follow a patient for a prolonged period of time frequently increase their claims risk by the practice of medicine by telephone. In instances where you are relying upon the patient's description of symptoms rather than physical examination, documentation becomes even more important. Your notes should include such statements as: "Upon questioning, the patient says there is no radiation of pain to the arms"; and "Patient says she has no other symptoms at this time."

Staff's Role:

Costly "Failure to Diagnose" cases have occurred when staff personnel have not been properly trained to obtain complete or crucial details when they take a message from the patient. The failure of staff to recognize the potential seriousness of post operative symptoms is a particular risk. In a knee surgery case, the postoperative patient called complaining of chest pain. The surgeon's office staff referred her to her family physician because they did not recognize any connection between the surgery and the symptoms. A "Failure to Diagnose Pulmonary Embolism" case resulted. Physicians should write protocols which delineate patient symptoms that require staff to promptly notify the physician.

A second area in which staff actions have resulted in "Failure to Diagnose" cases is where the physician is found to have inappropriately delegated authority for making medical decisions to his/her staff members. Some surgeons rely heavily upon their "nurse" to follow postoperative patients while the surgeon goes on vacation. In one plastic surgery case, the surgeon delegated responsibility to his "nurse" of 20 years to change dressings, diagnose postoperative wound infections and refer the patient to a covering physician if she felt it was needed. The "nurse" had no formal nursing education. Delay in diagnosis of a wound infection which required extensive surgery to correct could not be defended because the "nurse" was operating outside the scope of her legally permitted duties.

Summary:

Like many diseases, prevention of a malpractice case is much easier than the "cure" process via litigation. If you inculcate good prevention principles in your daily practice you can minimize risk of suit and concentrate on practicing good medicine.

REFERENCES

1. Texas Civil Appeal 608 S.W.2d 697.

SCIENTIFIC ARTICLE

Proximal Tibial Valgus Osteotomy

*The Veterans Administration Hospital Experience,
Wichita, Kansas, 1977-82*

M. BERNHARDT, M.D.,* R. L. PLASTER, M.D.,† and H. O. MARSH, M.D.,‡ Wichita

PROXIMAL TIBIAL VALGUS OSTEOTOMY is a well accepted and effective procedure for the treatment of degenerative arthritis primarily involving the medial compartment of the knee. The rationale for valgus osteotomy lies in the hypothesis that the physical overload on the medial compartment can be mechanically redistributed to the more normal lateral compartment. Other research indicates that a reduction in intra-osseous pressure by the osteotomy is responsible for pain relief.¹ Studies report excellent results in 80 percent of cases.^{2,5} A review of the recent experience with this procedure at this center did not compare favorably with the results reported previously, mainly because of technical errors in performing the procedure, particularly correction of the varus deformity.

The purpose of this article is to present the results at this center with valgus tibial osteotomy, identify the technical errors associated with this procedure, and present the protocol now utilized for the pre-operative planning and intraoperative management of patients undergoing this procedure.

Materials and Methods

Thirteen valgus tibial osteotomies were performed on twelve men ranging in age from 52 to 86 years (average 63 years, median 58 years) at the Veterans Administration Hospital in Wichita from 1977 through 1982. Each patient had medial compartment

knee pain not responding to conservative management (e.g., anti-inflammatory medications and walking aids). Angular deformities of the knee ranged from 1 degree of valgus to 11 degrees of varus. All patients had slight narrowing of the medial joint space or joint irregularity with osteophytes. Weight-bearing radiographs were obtained in most cases to evaluate the extent of lateral compartment disease. Osteotomy was not performed if the lateral compartment joint space showed gross narrowing, severe deformity, or cystic change of the subchondral bone.

The goal of surgery was to obtain correction of the deformity to a valgus alignment of 7 to 12 degrees. In all but one case a stepped staple was used for internal fixation. Postoperatively, all patients were placed in a long leg cylinder cast.

The evaluation of patients for this study was done by two or more of the following methods: telephone interview, personal interview and examination, chart review, and follow-up radiographic examination. The length of follow-up varied from 1 to 75 months (average 25 months). One patient died of causes unrelated to his surgery three years after the osteotomy.

Results

Results were classified as good, fair, or poor according to the following criteria: 1) good — pain was relieved completely or well controlled with non-narcotic analgesic medication; 2) fair — pain was decreased, but function was still compromised; 3) poor — pain was minimally relieved or unimproved.

Two patients were lost to follow-up within two months of their surgery and were rated as having poor results; one may have had a staple in the articular cartilage and the other had an intra-articular fracture.

Of the thirteen osteotomies performed, seven os-

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‡Clinical Professor, Chief, Section of Orthopedic Surgery, Department of Surgery, University of Kansas School of Medicine — Wichita.

Address correspondence, reprint requests, and requests for a complete list of references to Mark Bernhardt, M.D., Dept. of Orthopedic Surgery, St. Francis Regional Medical Center, 929 N. St. Francis, Wichita, Kansas 67214. Telephone: (316) 268-5988.

teotomies (54 percent) produced good results, one (8 percent) produced fair results, and five (38 percent) produced poor results.

Subsequent total joint replacement was not necessarily indicative of a poor result. One patient had relief of his symptoms for four years, but required a total knee replacement at age 58, five years after his osteotomy. Three other patients required subsequent knee arthroplasty. They had surgery within 1½ years after the osteotomy, and all fell into the poor result category.

After analysis of the pre- and postoperative radiographs and correlation of these observations with the results, the primary causes of poor results were believed to be due to technical errors. The most common error was under-correction of the deformity (an angle of less than 7 degrees of valgus obtained), occurring in six cases. Fracture into the joint occurred in four cases as a result of the failure to continue the osteotomy all the way to the medial tibial cortex. A fracture of the proximal fragment into the joint then occurred when the wedge osteotomy was closed. This type of fracture accounted for two of the five poor results.

Poor staple placement was another technical error. In three cases, the staples were not securely placed into bone, but did not adversely affect the outcome. In another case, the proximal fragment was small, and a portion of the staple was thought to be within the articular cartilage, probably leading to a rapid progression of lateral compartment arthritis and subsequently a poor result.

One patient developed a non-union which required bone grafting eight months later. He also developed a painful pseudarthrosis of his fibular osteotomy site requiring excisional osteotomy. This patient obtained a good subsequent result and was pain-free five years later.

Rationale for Protocol

The goals of osteotomy are to decrease pain and increase functional activity, to delay or arrest the progression of the degenerative disease and, in some cases, to delay the necessity of arthroplasty until the patient is older. Analysis of the errors in this study led to the development of the following protocol for patient selection and preoperative planning.

Patient Selection

Patient selection conforms to the current literature. All patients must have only medial knee joint complaints. These complaints should be sufficiently severe to limit daily function. Initial management con-

TABLE 1
METHOD OF GRADING PAIN AND FUNCTION⁶

Pain

1. Severe, spontaneous.
2. Severe on attempt to walk; prevents all activity.
3. Tolerable; permits limited activity.
4. Present only after activity; disappears quickly with rest.
5. Slight or intermittent; decreases with activity.
6. No pain.

Function

1. Bedridden or able to walk a few yards with two sticks or crutches.
2. Duration and distance of walking very limited with or without sticks.
3. Limited with one stick (less than 1 hour); able to stand for long period.
4. Long-distance walk is possible but limited without aids.
5. Walking without aids but has a limp.

sists of a trial of ambulatory aids, quadriceps rehabilitation, and anti-inflammatory medication. If conservative measures fail, the patient is a candidate for valgus tibial osteotomy.

Absolute contraindications include tricompartment degenerative disease, severe ligamentous laxity, lateral subluxation, varus deformity greater than 15 degrees, range of motion less than 70 degrees, flexion contracture greater than 20 degrees, loss of lateral joint space or the presence of large lateral spurs, cysts, or sclerosis on radiographs, and increased uptake in the lateral compartment on bone scan. The presence of small lateral spurs is accepted. In addition, if synchronous bicondylar contact is not possible because of excessive medial compartment wear, causing the femoral condyles to "teeter" on the tibial intercondylar eminences, then osteotomy should not be done.

Relative contraindications include age greater than sixty-five years and moderately severe patellofemoral degenerative disease. Osteophytes on the patella are not considered indicative of advanced patellofemoral compartment disease. To diagnose this condition, radiographs must identify joint space narrowing on the sunrise view.

The patient's pain and function are graded according to the method of Merle d'Aubigne (Table 1).⁶ Radiographic assessment of each compartment of the knee is graded according to Harding's modification of Kellergren's classification (Table 2).⁷

Preoperative Planning

Radiographs of the knee must be weight-bearing to allow accurate measurement of alignment and evaluation of the articular surfaces. Standing true an-

TABLE 2
RADIOLOGICAL ASSESSMENT⁷

Grade

0. Normal.
1. Slight narrowing or irregularity of joint space.
2. Slight narrowing or irregularity with osteophytes.
3. Moderate narrowing, sclerosis and osteophytes. Possible deformity.
4. Gross narrowing. Severe deformity and cysts.

teroposterior long radiographs (14 x 17 inches) of the knee are obtained. The femorotibial angle is determined by the intersection of the long axis of the femur and tibia as described by Bauer. Although this method is not as theoretically correct as that described by Harris and Kostuik⁵ and the three-point measurement of Edholm, *et al.*,⁸ it is the simplest, most convenient and most widely used method. Thirty-six-inch-long radiographs are taken in cases where bowing of the femur or tibia is present and a better view of the mechanical axis is needed.

Calculation of the amount of correction needed is done by adding 5 degrees to the difference between the femorotibial angle and the normal 7 degrees of physiologic genu valgus. A radiopaque ruler is placed next to the leg when the films are obtained to allow accurate determination of the size of the osteotomy wedge (Figure 1). This obviates the need

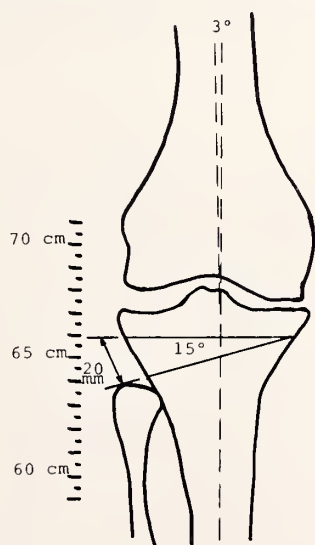


Figure 1. The wedge osteotomy is planned from the preoperative radiograph. In this example, the varus angulation is 3 degrees. The desired final femorotibial angle (12 degrees) includes 5 degrees of "overcorrection." To obtain this goal, a 15-degree wedge of bone must be removed. A line is drawn 1.5 cm distal and parallel to the tibial plateau, and the line of osteotomy is drawn from the medial cortex. Using a radiopaque ruler, which eliminates the need to adjust for magnification, the lateral width of the osteotomy is measured to be 20 mm.

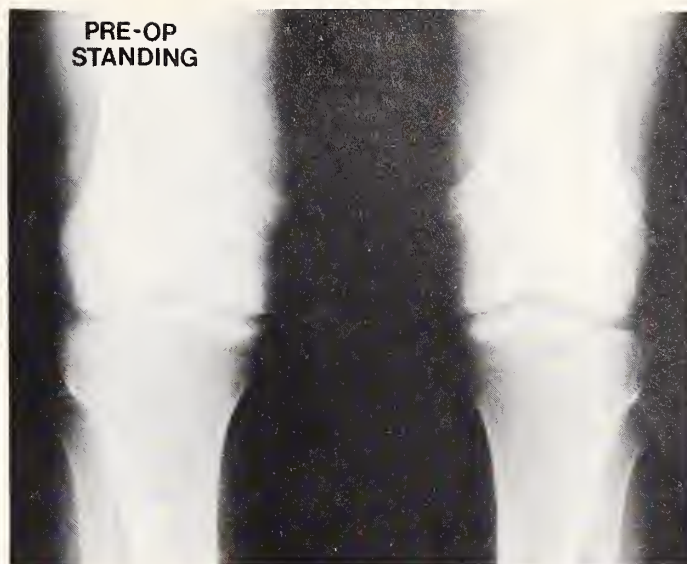


Figure 2. This is a weight-bearing anteroposterior radiograph of a fifty-seven-year-old man's knees. He had a five-year history of increasing right knee pain about the medial side. The radiograph shows some medial joint space narrowing and a varus deformity of the right knee with the femorotibial angle measuring zero degrees.

to adjust the measurement for magnification produced by the distance of the leg from the film. Estimation of the size of the wedge using the "1 degree equals 1 millimeter" rule is not done, as it leads to undercorrection of the deformity in males.³

Discussion

In larger series of valgus tibial osteotomies reported in the literature, minimal complications have been encountered.^{2,5} Undercorrection of the varus deformity is, however, the most common complication reported, ranging as high as 40 percent in one series.⁹ Undercorrection was the most frequent complication in this study. Other reported complications include peroneal nerve palsy, delayed- or non-union, fracture, infection, deep venous thrombosis, anterior tibial artery injury, aseptic necrosis of the proximal fragment, muscle compartment syndrome, and improper staple fixation. Fractures into the joint, improper staple fixation, and non-union were other complications noted in this series.

Fracture into the joint in this series, in contradiction to previous reports, did influence the outcome after osteotomy. In several cases an incomplete osteotomy and the subsequent unreduced fracture within the joint created a "teeter" effect and led to a poor result. However, when a fracture was recognized and reduced, it did not adversely affect the outcome after surgery.

The results in this review did not compare favorably with those previously reported. However,



Figure 3. Shown here are anteroposterior and lateral radiographs of the patient's (see Figure 2) right knee after proximal tibial valgus osteotomy.

a recent series from another Veterans Administration hospital reported similar results and complications.⁶ The nature of the veteran population, being more compensation- and disability-oriented, may be in part responsible for the less favorable results. However, intraoperative technical errors also played a significant part in the less favorable outcomes. By using the protocol presented, technical errors have been significantly reduced at this center.

Summary

Proximal tibial valgus osteotomy is a procedure

MEDICINA ET LEX (Continued from page 273.)

porting the principal opinion have taken it upon themselves to determine the wisdom and propriety of the statute and to conclude the statute is 'counter-productive,' contrary to the dictates of *Moody* and many earlier cases. In doing so, the decision ignores the record before the court."

That the majority of the court have acted in this fashion is extremely disappointing to health care providers. Unfortunately, this decision may portend the fate of House Bill 2661 adopted the following year, which enacted numerous changes in the tort law. Already the actuaries employed by the Insurance Commissioner have projected substantial increases in the surcharge as a result of the court's decision.

Apparently the majority of the court will apply the rational basis test to determine whether a physician shall be obligated to pay the surcharge but will not apply the same test to determine the constitutionality of statutes governing the payments from the Fund. There is not one decision across the United

which demands careful preoperative planning and precision in operative technique to avoid technical errors. The protocol described is now used at the Veterans Administration Hospital in Wichita.

Acknowledgment

We thank Peggy Gardner, Ph.D., and Judy Dusek, R.N., M.Ed., for reading and reviewing material; Steve Griffith for photography; Jes Smithback for graphics; and Sandy Burba for secretarial assistance.

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States in which a court has struck down such a statute based upon the rational basis test.

The implications of this decision will be felt for years. The court has adopted an entirely different philosophy and unique approach to the test of constitutionality, which five justices do not endorse. The broad language calls into question the Kansas Automobile Injury Reparations Act, the Worker's Compensation Act and numerous other provisions enacted over generations by the Kansas Legislature to meet the circumstances of particular issues. In the instant case, the majority of the court totally ignored the reality of the health care reimbursement system by which a liability insurer pays a verdict and consequently increases premiums, which in turn leads to increased charges, which are then paid by Blue Cross and Blue Shield and other health insurers, which in turn increase their premiums to the public. The only beneficiaries of the collateral source rule are the plaintiff and the plaintiff's attorney in the lawsuit lottery which results.

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EDITORIAL COMMENT

Dilemma du Jour

ETHICS AND MORALITY (the two coupled pretty well cover this somewhat problematic concept) provide editorialists with a happy basis for pontificating from time to time. They are always available, applicable to any situation, and subject to enough latitude of interpretation that observations are at once contentious and defensible — the real stuff of editorials.

Nothing exemplifies better the transition of medical practice from its form a half-century or so ago than the current public involvement in medical morality. Apart from certain basic legal controls, medical decisions were generally reached by physician recommendation (often tantamount to dictation) and patient acceptance. Paternalistic it may have been, but it was accepted as the norm and served well at the time. The ethics and morality of the matter were dictated by a more limited capability.

This comfortable state, however, has given way to the dilemma of ethical and moral decisions as they have been confounded by cathode rays, transistors, diodes, bytes and their ilk. The patient has been altered from medical challenge to electronic program. Both physician and patient are confronted with problems and possibilities which were formerly dismissed as impossible. A seemingly new world of ethical-moral complexities now extends from the earliest moments of reproduction (or before) to the last scientifically verified termination. If the focal point is the patient, the physician is accountable (this, at least, never seems to change), and this accountability seems to reflect both the ecstasy of accomplishment and the agony of forced accommodation.

The medical ethical-moral complex stems, in part at least, from the broad range of medical decisions which it seeks to cover. After all, the essence of an ethical-moral structure is that it should underlie all situations occurring in the discipline in which it operates. The closest we have come is the periodic reminder from some quarter that the physician's primary duty is to sustain life and do no harm in the process.

But this umbrella of over-simplification is becoming strained as the profession is faced with heavy medical weather. Medical capability becomes medical necessity, and the ethical-moral limits become

untenable as the profession seeks to accommodate the developing order. The essence of the medical dilemma is the question: do the ethical-moral tenets control the service, or does the service control the ethics? Notwithstanding the fact that much routine medical care is not affected by these unsettling developments, the profession must meet the latter with some degree of unity and vision or find its functions controlled by others. This, of course, means the coalescing of physicians' personal ethics of whatever source with the group ethical-moral complex and guarantees that "medical ethics" will never mean quite the same thing to every practitioner at any one time.

The currently dramatic technology of medical service tends to obscure one of the more compelling conditions which will profoundly affect medical ethics. The world has been informed that it now has in excess of five billion of us to contend with. The sociologic and demographic concerns expounded and the even more alarming projections for the future are of no greater moment than the medical concerns — in fact, they are inseparable. Medical service will be at least as important as feeding, clothing and housing the multitudes — and will present more ethical problems (including the increasing content of elders).

We are, then, in the midst of a planetary revolution. Our cultures and ethics originated from a world of isolated communities largely self-dependent and fostering population growth to provide the work capacity to the group, whether for agrarian, mercantile or military service. The stimulus to medical care (as well as its character) was expedient, depending upon the role of the patient in the group and the threat to the group. The physician was admonished to sustain life, no more for the patient than for whatever communal good was obtained.

We — the total society — have done too well. Now, physicians guided through the centuries by firm (and parallel) convictions must approach the question: where does the principle of unrelenting sustenance of life clash with its companion, *primum non nocere*? — D.E.G.



MEDICINA ET LEX

Collateral Source Statute Held Unconstitutional

WAYNE T. STRATTON, J.D.,* *Topeka*

ALMOST EIGHT MONTHS after the original argument, the Kansas Supreme Court issued its opinion upon the constitutionality of the statute modifying the collateral source rule. The collateral source rule is a common-law rule which allows plaintiffs to claim expenses incurred from an injury, even though they have been paid by a third party. In a malpractice case, plaintiffs will customarily receive the benefits from their insurance policies and then seek reimbursement from the physician or hospital they claim committed malpractice.

In 1986, the Kansas legislature acted to change this doctrine by passing a statute which provided that evidence of such repayment is admissible in a malpractice action. Twenty-nine states have passed statutes modifying this rule, and the Kansas statute was almost identical to the statutes passed years ago in California and Arizona which were both held constitutional by the supreme court of each state.

The Kansas Supreme Court's decision is difficult to understand. It actually consists of three positions, each held by a minority number of the members of the court. Four justices held that since this statute applied only to medical malpractice actions it was a suspect classification. Consequently, the test of its constitutionality would be whether the party asserting its constitutionality could demonstrate a compelling state interest justifying the classification. The court further held that the right to recover in such an action is a fundamental interest justifying this heightened scrutiny test of constitutionality.

Two justices who joined in the majority decision then filed a concurring opinion arguing that the test to be applied should be the rational basis test, which



Mr. Stratton's discussion topics are selected for their medicolegal interest to physicians. Readers are invited to submit questions or items of interest in this area for attention in this series.

test requires consideration of whether the classification bears some reasonable relationship to a valid legislative objective. They found the statute did not meet this criterion.

Three members of the court dissented. They concluded that the proper test to be applied is the rational basis test, and that under this test the statute was clearly constitutional. The dissenters emphasized that the function of the court is limited to interpretation and enforcement of the laws and acts by the legislature. Only if a statute is clearly unconstitutional may the court strike down an act of the legislature. They further stated that the personal views and beliefs of the members of the court must not be allowed to control their consideration of legislative acts. The dissent noted that the legislative history of K.S.A. 60-3403 consists of some 422 pages. The dissenters stated: "The justices sup-

(Continued on page 270.)

*KMS Legal Counsel.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE, or the Kansas Medical Society. For further information, contact Mr. Stratton, 215 E. 8th, Topeka KS 66603, 1-800-332-0248.

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BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Packs of 100. The tablets are embossed with MARION/1712.

Issued 3/84

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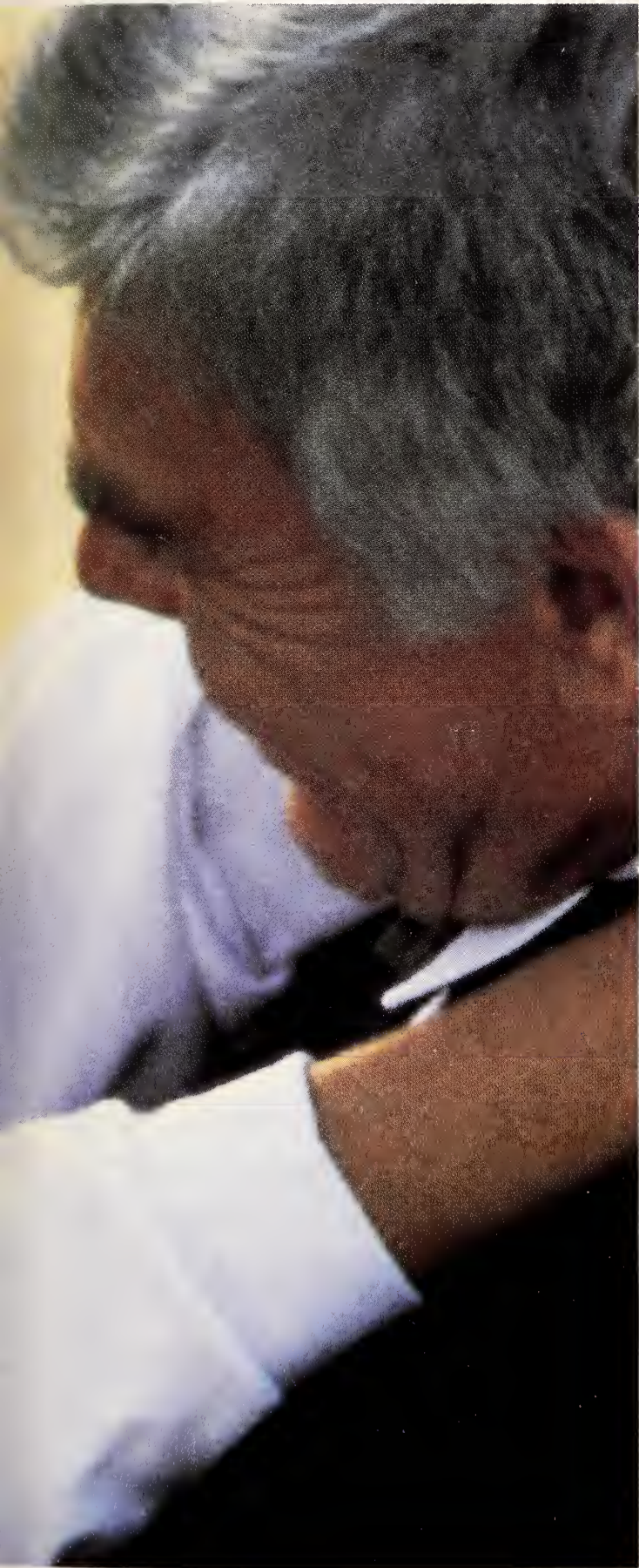
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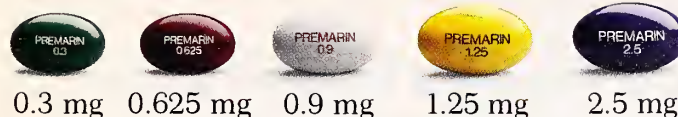
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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)

PREMARIN® Brand of conjugated estrogens tablets, USP
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1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA.

Three independent, case-controlled studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case-controlled studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semi-annual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equi-estrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case-controlled study estimated a 4.7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17 α -dihydroequilin, together with smaller amounts of 17 α -estradiol, equilin, and 17 α -dihydroequilin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe vasomotor symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens Vaginal Cream) is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (see Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Estrogens have been reported to increase the risk of endometrial carcinoma (see Boxed Warning). However, a recent large, case-controlled study indicated no increase in risk of breast cancer in postmenopausal women. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

For atrophic vaginitis

PREMARIN® (conjugated estrogens)

Vaginal
Cream
0.625 mg/g



Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Pre-existing uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. It jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not yet complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

- Increased sultobromophthalein retention.
- Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.
- Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T_4 by column, or T_4 by radioimmunoassay. Free T_3 resin uptake is decreased, reflecting the elevated TBG; free T_4 concentration is unaltered.
- Impaired glucose tolerance.
- Decreased pregnandiol excretion.
- Reduced response to metyrapone test.
- Reduced serum folate concentration.
- Increased serum triglyceride and phospholipid concentration.

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating, cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme, erythema nodosum; hemorrhagic eruption, loss of scalp hair; hirsutism, steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate-to-severe vasomotor symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 mg to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically.* Osteoporosis: Female castration. Osteoporosis —0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off). Female castration —1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three- to six-month intervals.

Usual dosage range: 2 g to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

- Lindsay R, Hart DM, Clark DM: The minimum effective dose of estrogen for prevention of postmenopausal bone loss. *Obstet Gynecol* 1984;63:759-763.
- Studd JWW, Thom MH, Paterson MEL, et al: The prevention and treatment of endometrial pathology in postmenopausal women receiving exogenous estrogens, in Pasetto N, Paoletti R, Ambrus JL (eds): *The Menopause and Postmenopause*. Lancaster, England, MTP Press Ltd, 1980, chap 13.

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Vomiting	Nausea	Headache	Anorexia	Constipation
Reduced 90%	Reduced 86%	Reduced 72%	Reduced 62%	Reduced 60%

- Only 1/3 the dropout rate due to side effects of amitriptyline alone, although the incidence of side effects is similar¹

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

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In moderate depression and anxiety

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Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) ^{IV}

Limbitrol[®] DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) ^{IV}

References: 1. Feighner JP, et al. *Psychopharmacology* 61:217-225, Mar 22, 1979. 2. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

Limbitrol[®] ^{IV} Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Togomet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs.

Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring

reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias at the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for monitoring and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage at three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt). Available in bottles at 100 and 500; Tet-E-Dose[®] packages at 100, Prescription Paks of 50.

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Please see summary of product information on adjacent page

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Partial Duodenal Obstruction

Secondary to Meckel's Diverticulum	289
The Five-Session Quit-Smoking Clinic	291
Malpractice '87: Status and Solutions (Part 2)	294
Tort Reform	301
KMS Newsletter	290a

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Volume 88, Number 10, October 1987

Contents

Scientific Articles

- Partial Duodenal Obstruction Secondary to
Meckel's Diverticulum
Warren E. Meyer, M.D., Wichita 289
Case report from St. Joseph Medical Center
- The Five-Session Quit-Smoking Clinic
Bruce S. Liese, Ph.D., and David A. Govaker, M.D.,
Kansas City, Kansas 291
*A smoking cessation program developed at the
KUMC Department of Family Practice*

Special Feature: Malpractice

- Malpractice '87: Status and Solutions
M. Martin Halley, M.D., J.D., Topeka 294
*The second of a two-part article on the malpractice
situation at the state and the national level*
- Tort Reform
Mortimer B. Zuckerman 301
*An editorial by the Chairman and Editor-in-Chief
of U.S. News & World Report*

Miscellaneous

- Classified Advertisements 301
- Cover Story 278
- Editorial Comment: The Necessary Evil..... 280
- Impaired Physician Program 281
- Information for Authors 304
- KFMC Update 282
- KMS Newsletter 290a
- Medicina et Lex: The Liability of Drug Manufacturers
and Physicians 298
- Physician Directory 302
- President's Message 286

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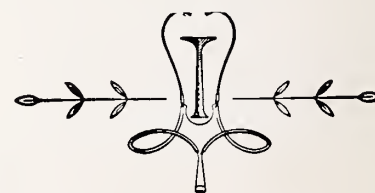
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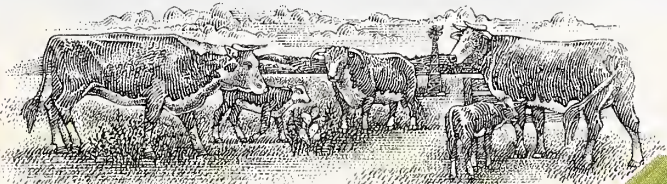
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Good News For People Who Eat.

If your taste buds are not altogether excited about a future of organic fiber flakes, the beef industry would like a few words with you. Even a few from the U.S.D.A. Because the lowdown on beef is probably less than you think—lower in calories, leaner on fat, lighter on cholesterol than you would ever imagine. It's even faster to fix than your mother knows. So read on. And hang on to your forks.



THE LOWDOWN ON CHOLESTEROL

True fact: beef has only 76 milligrams of cholesterol in a 3-ounce serving. That's only average. Wonderfully average.

GOOD NEWS FOR PEOPLE WHO COOK

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TERIYAKI BEEF STIR-FRY

Preparation: 15 min.
Cooking time: 10 min.
Cut 1 lb. top round steak in thin strips. Marinate in 3 Tbs. teriyaki sauce, 1 Tbs. oil and 2 tsp. cornstarch 30 min. Stir-fry 2 bell peppers (¾" cube) and 6 green onions (2" pieces) in 1 Tbs. oil 3 min., remove. Stir-fry beef (½ at a time) 2-3 min. Return all ingredients. Cook until hot. 4 servings.
Calories: 247 per serving, 162 from beef.

Figures are for 3-ounce servings, cooked and trimmed.



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ROUND TIP

6.4 gms total fat*
(2.3 gms sat. fat)
162 calories



TOP LOIN

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(3.0 gms sat. fat)
172 calories



TOP ROUND

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162 calories

Beef.

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Source: U.S.D.A. Handbook No. 8-13



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155 calories



TENDERLOIN

7.9 gms total fat*
(3.1 gms sat. fat)
174 calories



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7.4 gms total fat*
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Cover

(Photograph by Edwin D. Rathbun, M.D., with a Nikon camera equipped with a 200 mm telephoto lens.)

The plane strikingly silhouetted against the Liberal, Kansas sunset was a product of the Funk Airplane Company, founded by Joe and Howard Funk in Akron, Ohio. This plane, made in 1934, was powered by a 63 HP Ford Model T engine.

Although the plane was Ohio-born, it was destined to have some 200 Kansas-made siblings, as the Funks moved their operation to Coffeyville in 1941. A temporary casualty of WW II, the plant was closed down in 1942 but reopened in 1945, continuing production until 1948.

Dr. Rathbun, who loves planes as well as cameras, notes that he longed for just such a plane, which he planned to paint blue. This would make way for the report that he had left in a blue Funk. (KANSAS MEDICINE accepts no responsibility for that.)



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To show you how many
hypertensives stayed on

INDERAL[®] LA
(PROPRANOLOL HCl)

after a major nationwide trial...



An aerial photograph of a large, modern stadium at night. The stadium is filled with spectators, and the football field is brightly lit. The stadium is surrounded by a city, with a highway and mountains visible in the background. The text "...we had to find just the right room." is overlaid on the image.

...we had
to find
just the
right room.

60,073 patients (90%) who started on INDERAL[®] LA stayed on INDERAL LA.^{1*}

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keeps looking better**

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NOW AVAILABLE...

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DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema) —PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T₄ and reverse T₃, and decreasing T₃.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case, this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should

be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbital, and rifampin accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and lidocaine have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T₃ concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL (propranolol HCl) is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy, visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION — Dosage must be individualized. The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS — Dosage must be individualized. Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE — Dosage must be individualized. The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS — 80-160 mg INDERAL LA once daily. PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

REFERENCES:

1. INDERAL LA National Compliance Evaluation Program. Data on file, Ayerst Laboratories.
2. Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxprenolol, atenolol, and metoprolol given once daily. *Arch Intern Med* 1985; 145: 1321-1323.

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EDITORIAL COMMENT

The Necessary Evil

A COMMUNICATION from Yugoslavia in a recent *NEJM* brings into focus a problem which suggests that a relatively wealthy capitalist democracy and a relatively poor socialist state may have medical problems of varying degree but common essence. Despite the political philosophies and rhetoric that divide those governments, these problems are based on that vexatious agent, money.

In this case, the article dealt with the challenge of providing organ transplants, a service noted for staggering costs. Without stated intention, it points to the fact that the availability of an extraordinary service in one area brings demand for that service in other areas. In health matters, this means that the less-affluent countries are forced, initially at least, to send those in need of such services to countries where they may be obtained, a matter realistically determined by whether funds are available. In the case of this communist country, the bill is paid entirely by the state — if approved, that is, by the “health parliament,” composed of elected representatives from hospital, factory and neighborhood. Since money is always in short supply (whether dinars or dollars), this leads to the practical solution of budgetary accommodation: short some other area.

The example cited, a blood-marrow transplant, is estimated at costing \$100,000. A certain perspective is gained when it is pointed out that their medical school cannot afford to subscribe to foreign medical journals. Such decisions of allocation of money and resources take on a grim aspect in a country where, for example, infant deaths exceed 40 per thousand births. The Yugoslavs are approaching the transplant matter by trying to develop the performance of such procedures at home — commendable but not an overnight capability — and during this “catch-up” time, the “haves” will have moved on ahead.

If the present public attitude and medical potential continue, regardless of locale, it is certain that the matter of providing the most advanced medical care possible not only is going to continue but is going to grow, since it lies in fertile public ground and is nurtured by medical dedication, patient demand and compelling media reports. Basic economics assure that, while some reduced costs for accepted pro-

cedures (as well as the obsolescence of others) may be accomplished, the process propagates new — and again expensive — procedures. This in turn leads to various types of government funding, wholly or in part, of health care supplementing private and personal resources, as well as a variety of non-governmental philanthropies.

So the limits of allotted resources mean that there will always be some deprived of total service. The unpleasant extension of this condition is that cost is becoming an increasing presence in matters of optimum medical care — including survival. Does this mean that “lack of funds” becomes acceptable as a secondary cause of death? Will statisticians come to classify a death as “preventable” on the basis of the economics of the case?

The suggestion of similarities between these two disparate countries is not to discount our own system in relation to those communist areas. It stresses, rather, the accomplishments that our economic system has provided this country and suggests that those “classless” societies, even if they reach our current level of service, will still have a considerable gap to challenge them — produced as much by their own characteristic bureaucracies as by their professional medical capabilities.

Changing patterns of medical service and economics are by no means subtle but are obscured by the profession’s being so embroiled in today’s compelling demands (engendered by its successes) that proper and well organized plans for tomorrow’s medical structure may be projected in philosophic pronouncements but rarely attain any maturity of effect before new conditions appear on the scene.

Mankind’s continuing quest for improved health (with its implied goal of eternal life) has been and always will be a financial burden in a world that enjoys spending its money elsewhere. Are the communist countries moving toward our ways — or is our process of evaluating our own medical needs closer to “health parliaments” than we care to admit? — *D.E.G.*



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KFMC UPDATE

Editor's Note: In keeping with its policy of offering continuing information regarding medical activities, KANSAS MEDICINE continues the serial offering prepared by G. Rex Stone, M.D., Medical Director of the Kansas Foundation for Medical Care. These articles will keep Kansas physicians abreast of KFMC-related matters.

DURING our regional meetings in August 1987, I discovered that most physicians, and many hospitals, were unfamiliar with Health Care Financing Administration (HCFA) defined prohibited actions under the Prospective Payment System (PPS). For this reason, I am dedicating this space to a discussion on Medicare-prohibited actions and their consequences to the physicians and hospitals of Kansas.

In July 1985, HCFA issued instructions to all PROs for a special type of denial PROs must issue if they determine a hospital or physician is trying to circumvent the PPS. These attempts may be through unnecessary admissions, inappropriate

readmissions and inappropriate transfers within a hospital. These instances are called "Prohibited Actions" and are treated differently by the government because of the perceived intent to game the system at the expense of the patient.

The four areas in which a prohibited action denial should be issued are:

1. The premature discharge of a patient that results in the subsequent readmission of the patient to the same hospital.
2. The readmission of a patient for care that should have been provided during the first admission.
3. The admission of a patient to an acute-care part of a hospital, even though the medical record shows that the patient required initial care in a PPS-exempt unit within the hospital (such a bed was available), and the patient is subsequently transferred to the PPS-exempt unit (this could be psychiatric, rehabilitation, drug/alcohol or swing-bed).
4. The transfer of a patient from a PPS-exempt

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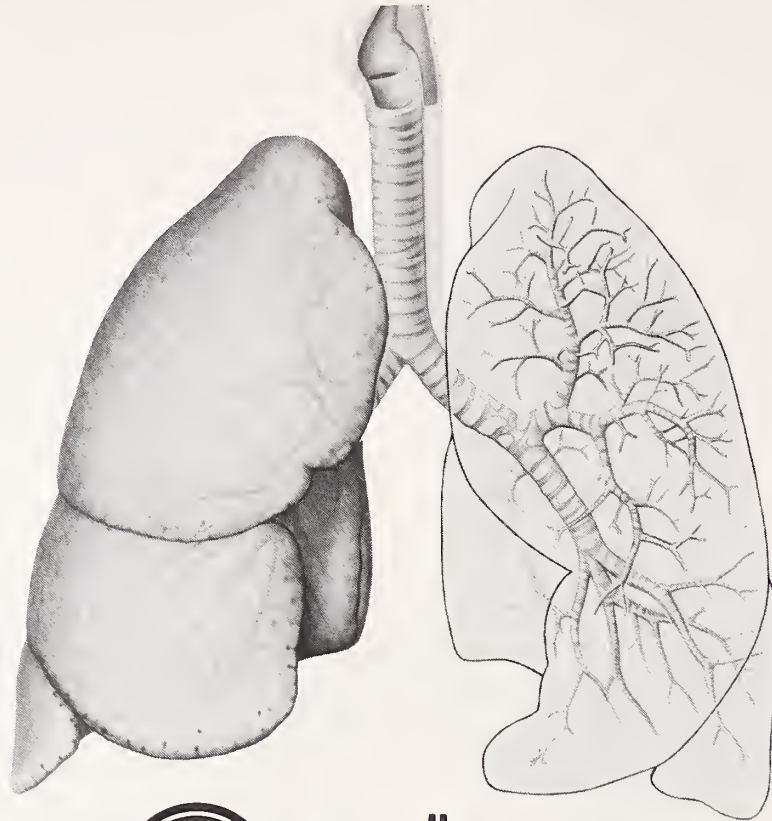
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Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Ceclor[®] (cefactor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication:
Known allergy to cephalosporins.

Warnings:

CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients. Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness,

insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.
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unit to an acute part of the hospital when the patient requires only the level of care being provided in the exempt unit, including swing-beds.

Whenever one of these actions is identified, KFMC is required to deny the second portion of the stay. This is no different from other admission denials, but HCFA has gone one step further on these cases. Whenever a physician or hospital has two prohibited action denials with service dates in one calendar quarter, KFMC *may* initiate a sanction report. However, if three or more denials in a quarter are identified, KFMC *must* initiate a sanction. If the denials are all for one physician in a hospital, the sanction recommendation will be for that physician, but if more physicians are involved, the sanction may be against the entire hospital.

Although I mentioned that the second portion of the stay will be the denied portion, the physician included in the sanction report will be the one responsible for the premature discharge or inappropriate transfer. In that way, the receiving physician will not be penalized.

Each physician in Kansas needs to be aware of this type of denial and its significant impact not only on individual physicians, but on their work-

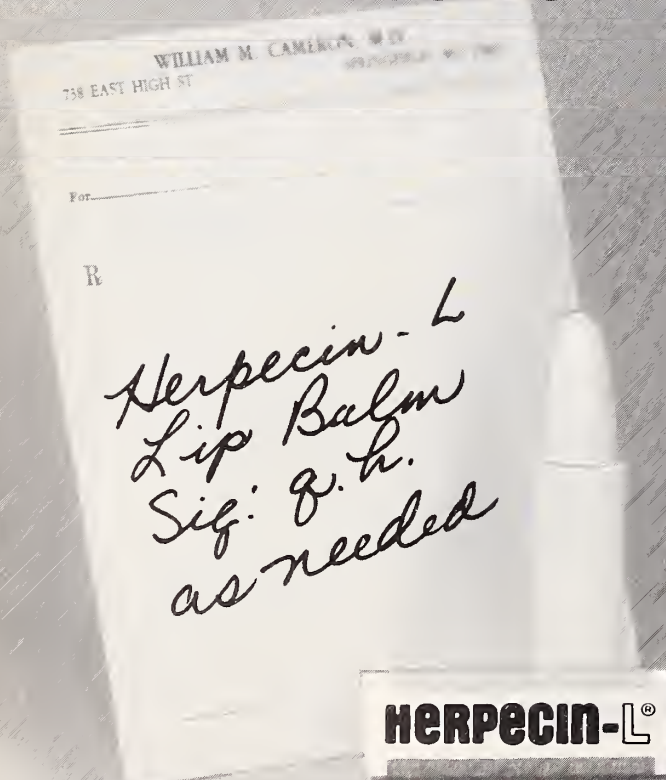
place. You should make every attempt possible to document clearly your reasoning for intra-hospital transfers and routine patient admissions and discharges. If there is adequate documentation supporting the need for one of these actions, it will not be denied. For example, if a discharge is patient-initiated, no matter what the status of the patient at time of discharge, it will not be denied as a prohibited action. Similarly, if a patient is transferred between exempt and acute units because of care needs, this should be documented in the medical record.

KFMC does not want to begin punitive action against a physician or hospital any more than you want us to. Sanctioning is a difficult process established to deal with physicians and hospitals who are practicing bad medicine or are trying to manipulate the payment system. This is not happening very often in Kansas, and I do not want to see physicians or hospitals caught in these denials when additional attention to this area, through documentation, could prevent it.

If you have any questions about this, or any other areas of PRO review, please contact me at the KFMC office. — G. Rex Stone, M.D.



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PRESIDENT'S MESSAGE

Quality of Care

PROFESSIONALISM demands good care for our patients. Since physicians understand the body of scientific knowledge used to care for patients better than anyone else, only physicians are able to determine what the standards of care should be. Even though organized medical staffs, individual physicians and even patients have always monitored the quality of care rendered, now third-party payers are demanding more rigorous quality assessment with better documentation and greater accountability. Many businesses are also interested in quality medical care, but sadly, they often focus more on the cost of medical care. We need to keep in mind that frequently with cost-cutting care the quality may suffer. Physicians dealing with quality-of-care issues must be certain that "cost-effective" care measures up when quality is assessed. We must resist the provision of lesser-quality care, even if it is less expensive.

Quality care can be defined as care which consistently contributes to the improvement or maintenance of the quality or duration of life. The care must be in the best interest of the patient. It must look to the prevention of disease. It should be timely. It should allow the participation of the patient and the care providers to discuss the process of care. It must be based upon accepted principles of medical science. It must make efficient use of technology, and it must be sufficiently documented in the patient record to enable both continuity of care and peer evaluation. Developing standards by which to judge care is the responsibility of physicians.

Evaluation of physicians by their peers is the heart of quality assessment. To assure quality, assessment must be done by peers who have set criteria which are acceptable and based on valid scientific information. The tools to quantify quality are now being developed. Severity of illness adjusters are also being developed. And the review should be linked to some quality-assessment or risk-management program.

In Kansas, there are several organizations doing quality-of-care review. Most of us have been involved with the Kansas Foundation for Medical Care, because of its Medicare contract, and are familiar with the process of review. One problem which



presently is being addressed by the Kansas Medical Society, KFMC and the JCAH, is the quality of the review process itself.

We must continue with vigorous quality-of-care review. We need to focus on the severity of illness, and learn to better evaluate the gravity of the patient's condition. As physicians, we can assure third-party payers that their health care dollars are well spent, and at the same time better identify physicians who want to sacrifice quality medicine, merely to cut costs. Additionally, we can learn better ways to care for our patients, having participated in the assessment of the quality of care rendered.

I encourage you to be involved in the quality-care issue. We must remember that the measure of value equals cost plus quality. This is a subject that will continue to grow in significance as time passes. Let us be sure that conscientious, caring physicians are making the important decisions.

A handwritten signature in dark ink, reading "Donald V. Hutton" followed by a stylized monogram "D.V.H." to the right.

President

Before prescribing, see complete prescribing information in SK&F CO. literature or PDR. The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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Only conjugated estrogens tablets have established efficacy in both osteoporosis¹ and vasomotor symptoms* at 0.625 mg/day. No other estrogen, oral or transdermal, has established clinical evidence or minimum effective dose in both indications.

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PREMARIN is the most extensively tested estrogen, with an unsurpassed record of long-term safety.

And clinical evidence shows a significantly reduced risk of endometrial hyperplasia when cycled with a progestin.²

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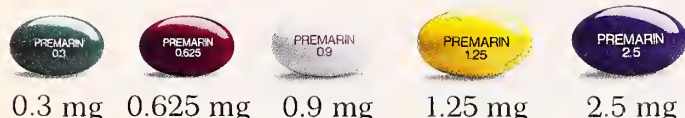
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*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary
of prescribing information.

For moderate-to-severe
vasomotor symptoms and
for osteoporosis

PREMARIN® (conjugated estrogens tablets)



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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream, in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA. Three independent, case-controlled studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case-controlled studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semi-annual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equi-estrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.
The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case-controlled study estimated a 4.7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares urine. It contains estrone, equilin, and 17 α -dihydroequilin, together with smaller amounts of 17 α -estradiol, equilin, and 17 α -dihydroequilin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe vasomotor symptoms associated with the menopause (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration. PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING)

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (see Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Estrogens have been reported to increase the risk of endometrial carcinoma (see Boxed Warning). However, a recent large, case-controlled study indicated no increase in risk of breast cancer in postmenopausal women. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

For atrophic vaginitis

PREMARIN® (conjugated estrogens)

Vaginal
Cream

0.625 mg/g



Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Pre-existing uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not yet complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

- Increased sulfobromophthalene retention.
- Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.
- Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T_4 by column, or T_4 by radioimmunoassay. Free T_3 resin uptake is decreased, reflecting the elevated TBG; free T_4 concentration is unaltered.
- Impaired glucose tolerance.
- Decreased pregnandiol excretion.
- Reduced response to metyrapone test.
- Reduced serum folate concentration.
- Increased serum triglyceride and phospholipid concentration.

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea, premenstrual-like syndrome, amenorrhea during and after treatment, increase in size of uterine fibromyoma, vaginal candidiasis, change in cervical erosion and in degree of cervical secretion, cystitis-like syndrome, tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating, cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued, erythema multiforme, erythema nodosum, hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only* For treatment of moderate-to-severe vasomotor symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 mg to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically:* Osteoporosis. Female castration. Osteoporosis — 0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off). Female castration — 1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three- to six-month intervals.

Usual dosage range: 2 g to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Lindsay R, Hart OM, Clark OM: The minimum effective dose of estrogen for prevention of postmenopausal bone loss. *Obstet Gynecol* 1984;63:759-763. 2. Studd JWW, Thom MH, Paterson MEL, et al: The prevention and treatment of endometrial pathology in postmenopausal women receiving exogenous estrogens, in Pasetto N, Paoletti R, Ambrus JL (eds): *The Menopause and Postmenopause*. Lancaster, England, MTP Press Ltd, 1980, chap 13.

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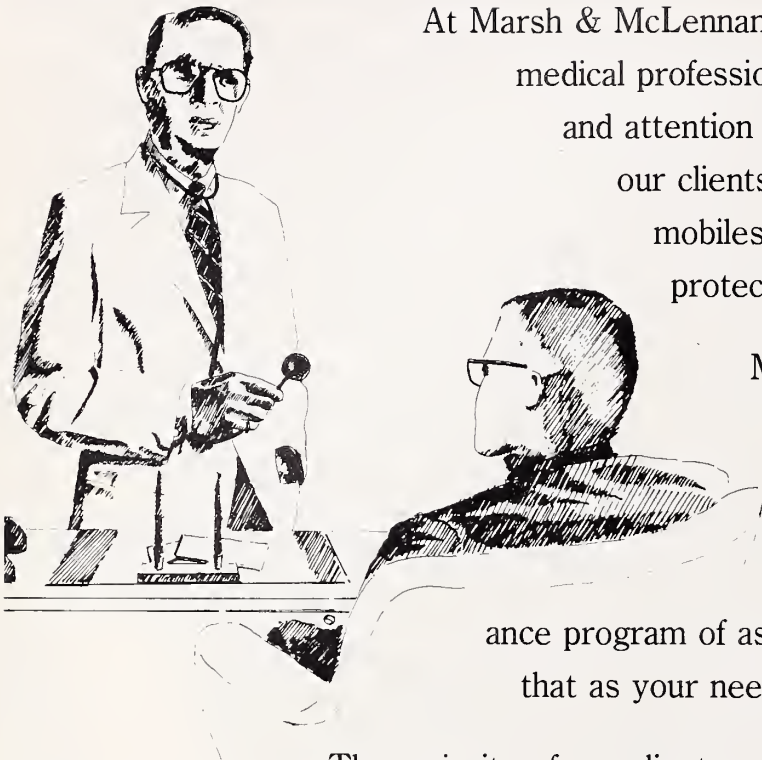
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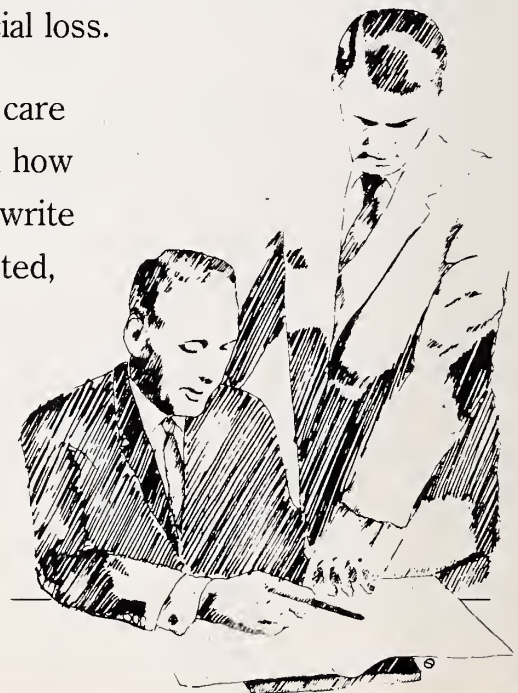
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SCIENTIFIC ARTICLES

Partial Duodenal Obstruction Secondary to Meckel's Diverticulum

WARREN E. MEYER, M.D.,* *Wichita*

MECKEL'S DIVERTICULUM results from failure of the omphalomesenteric duct to obliterate, and was first described in 1809 by Johann Friedrich Meckel. Although uncommon, its history and treatment have been controversial despite the fact that when it becomes symptomatic, its morbidity and mortality rates are 17.6% and 10.3% respectively.¹ Its status is aptly described by Dr. Charles Mayo's classic observation: "Frequently suspected, often looked for, and seldom found."²

Medical students are taught to remember Meckel's diverticulum by the rule of 2s: 2% of the population; two times as common in males as females; situated two feet proximal to the ileocecal valve; two types of heterotopic tissue (gastric and pancreatic); and two common complications (bleeding and perforation).

The reported complications of symptomatic Meckel's diverticulum are listed in Table I.¹⁻⁵

TABLE I
COMPLICATIONS OF MECKEL'S DIVERTICULUM

Obstruction

Intussusception
Littre's hernia

Bleeding

Heterotopic tissue (gastric and pancreatic)
with ulceration

Perforation

Acute inflammation
Ileal stenosis
Fistula

There is no question about the surgical treatment of symptomatic Meckel's diverticulum; the controversy has centered on the proper treatment when Meckel's diverticulum is discovered incidentally during surgery.

*From the Department of Surgery, St. Joseph Medical Center, Wichita.

Address reprint requests to Dr. Meyer, 1515 So. Clifton, Suite 420, Wichita, KS 67218-2920.

Solter and Bill argue against its removal, noting that only 4% of such cases will become symptomatic.³ An opposing view is taken by Mackey and Dineen, who favor removal in any male past 40 years of age to prevent future complications.¹

This case report will not resolve the controversy, but relates an unusual presentation of a symptomatic Meckel's diverticulum. A review of the literature has failed to show any similar case.¹⁻⁵

Case Report

A 65-year-old, well developed, obese Mexican-American male was admitted to St. Joseph Medical Center on January 19, 1984, with a history of repeated bouts of painless vomiting. The vomitus consisted of bile and/or food previously eaten. No blood, coffee-ground, or fecal emesis was noted. Symptoms had begun one to two weeks prior to admission. He had been seen by his physician in Wellington on January 3 because of chest pains. He was given Nitrobid, but this caused headaches, so he discontinued its use. He experienced pain radiating down both flanks to the bladder area without any urinary symptoms. On January 4, an intravenous pyelogram, barium enema, SMAC20, and urinalysis were negative. On January 10, he had a cardiac stress test, which was reported as negative. Because of the vomiting, he was admitted to Wellington Hospital on January 12 and remained there until the 16th. He improved with treatment consisting of nasogastric suction and intravenous fluids. Results of upper gastrointestinal studies were interpreted as showing hypertrophic gastritis (Figure 1).

The patient's past surgical history included appendectomy, 1966; splenectomy following an auto accident, 1968; left inguinal hernia, 1977; and right orchiectomy, 1979.

The vomitus, consisting primarily of food, recurred on January 18, and he was admitted to St. Joseph Medical Center, Wichita. Nasogastric suction was begun, as well as intravenous replacement of fluid and electrolyte losses. The gastric suction

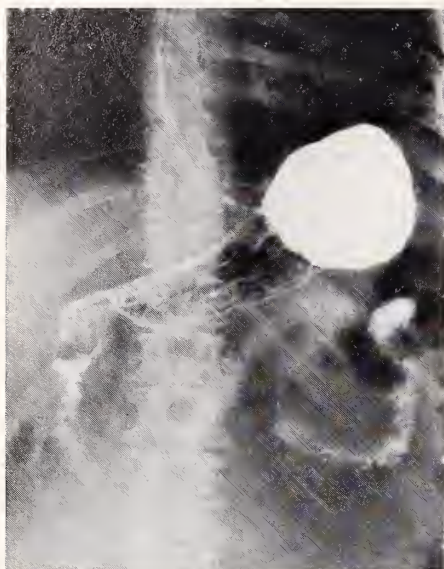


Figure 1. UGI from outside hospital.

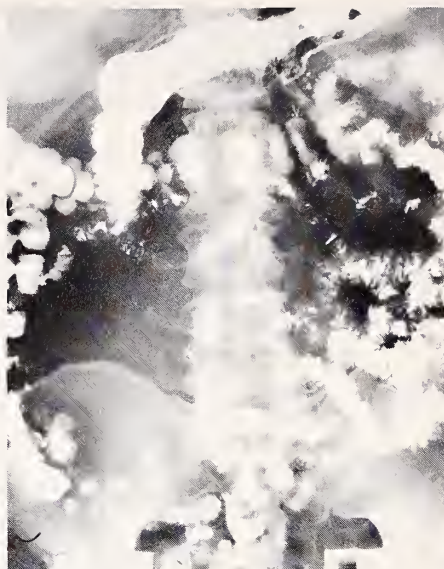


Figure 2. UGI done during admission discussed showing defect on the right side of the abdomen and dilatation of the first part of the duodenum.

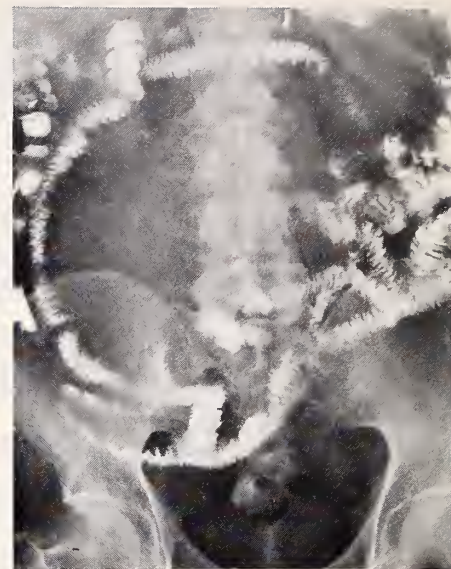


Figure 3. Small bowel study showing displacement of the small bowel by abdominal mass and the adjunct blood clots.

averaged 2500-3000 cc/day and consisted primarily of bile. Results of routine laboratory urinalysis and SMAC20 were within normal limits. Serum gastrin level was 348. On January 20, a gallbladder sonogram was interpreted as showing sludge, and a liver scan raised the question of hepatobiliary disease. An intravenous cholangiogram on January 23 yielded normal results. The upper gastrointestinal examination was repeated, along with a small bowel study on January 24, and the results are shown in Figures 2 and 3. There was a holdup of the contrast material in the second portion of the duodenal bulb where it turns into the third portion of duodenum. There is no sign of any obstruction, but the contrast material is held up on the two-hour film. The small bowel studies showed displacement of the ileum by a right-sided mid-abdominal mass.

On January 26, an exploratory laparotomy was performed. A mass about the size of the thumb was found in the distal ileum about two or three feet from the ileocecal valve and was adherent retroperitoneally. The mass was dissected, a retroperitoneal hematoma was entered, and old blood clots were removed. No fresh blood was noted. After the hematoma was evacuated, it was found to extend to the duodenum. It conformed to the mass noted on the small bowel study and was producing the extrinsic pressure noted on the third portion of the duodenum. The mass was excised and an ileo-ileal anastomosis performed. Biopsies of the edge of the cavity were taken. The pathology report showed a Meckel's diverticulum with heterotopic gastric mu-

cosa and perforation. Biopsies of the wall of the cavity showed only acute and chronically inflamed granulation tissue consistent with a dissecting hematoma.

The patient's postoperative course was uneventful, and he left the hospital on February 6. Subsequent followup has revealed a normal individual without recurrence of his symptoms.

It is interesting to note that the serum gastrin level was initially elevated to 348, but returned to normal (47) during the postoperative period. There have been reports of increased gastrin levels with complete or partial upper gastrointestinal obstruction; this may explain the elevated serum gastrin level here.

This case would seem to substantiate the argument of Mackey and Dineen for removal of a Meckel's diverticulum, since it fits their criteria. The diverticulum was overlooked during the patient's surgery in 1968, and its discovery and removal at that time would have prevented the subsequent disease process and the difficulty he experienced.

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OCTOBER 1987

MALPRACTICE UPDATE

The 1988 legislative session is shaping up to be another critical one for physicians, hospitals and other health care providers. The recent Supreme Court decision which invalidated one part of the comprehensive malpractice reform package has triggered a chain reaction which will probably result in more significant changes in tort reform efforts, insurance requirements and premium levels.

On July 17, the Kansas Supreme Court rejected the new law which for the first time would have ended double recovery of certain expenses involved in medical malpractice lawsuits. The so-called "collateral source rule" was just one part of a sweeping package of reforms which included caps on awards. The court's opinion is significant because it probably means the rest of the package is unconstitutional, too.

As a result of the court's action, premiums are expected to increase by as much as 70% next July 1, with the bulk of the increase coming in the surcharge premium every physician and hospital pays into the Health Care Stabilization Fund, the state-run pool which provides coverage up to \$1 million per claim for health care providers.

In view of the court's opinion on the collateral source rule, it is expected that the caps on awards will also be held unconstitutional in the near future. In light of these developments, the KMS and the Kansas Hospital Association intend to ask the Legislature to correct the constitutional problems with the main provisions of the tort reform legislation, by making the legislation apply across the board to all personal injury actions. Additionally, the concept of reducing the required amount of insurance carried by the Health Care Stabilization Fund is being analyzed to see if such a change is feasible.

In This Issue...

- Malpractice update
- Risk retention groups
- KMS actions
- KMS-IPP
- AMA in Washington
- HIV lab test results in medical records
- Exempt licenses
- AMA House of Delegates
- Professional patient
- KMS in action

RISK RETENTION GROUPS

Physicians should be cautious of a new insurance mechanism recently made available by virtue of federal legislation. Called "risk retention groups," these are insurance mechanisms which are exempt from control by state insurance laws. They generally have to meet lower capitalization and surplus requirements than traditional insurance companies. Many of these risk retention groups are beginning to market their insurance policies in Kansas, at rates which appear to be below the conventional cost. However, physicians should look closely before dropping their current insurance and going with a risk retention group. In some cases, the RRG may not have been "admitted" into the state to do business, and there are certain risks the physician assumes when signing on with

one of these groups. In any event, you are well advised to examine thoroughly any alternative insurance mechanism before you make the change.

KMS will be sending out detailed information on the options available to correct the malpractice legislation, and the plans which have been adopted for the upcoming legislative session. It is extremely important that you watch your mail for such information so that you can have a full understanding of how your coverage and premiums will be affected in the coming months. If you have any questions in the meantime, please contact the KMS office, 1-800-332-0156.

KMS ACTIONS

KMS Executive Committee, at its September meeting, discussed the membership issue and considered the options for revenue increases. While KMS dues ranked 47th in the nation, and at \$220 were well below the national average of \$322, it is assumed that a dues increase will produce some loss of membership. As a short-term possibility, however, this choice appeared most practical. The Committee also decided to recommend the following candidacies to AMA offices: Roger D. Warren, M.D., Hanover, to AMPAC Board; Alex Scott, M.D., Junction City, to AMA Council on Long-Range Planning and Development; and Jimmie A. Gleason, M.D., Topeka, to AMA Council on Legislation. KMS Council subsequently met and voted to increase the 1988 membership dues by \$100. At \$320, Kansas dues will still be below the national average. The Council also authorized the Executive Committee to establish a special assessment on each member for professional liability activities. A feasibility study for the formation of KMS Liability Insurance Company was approved. The Council heard updates on the AIDS Task Force, the retirement program for KMS membership and the Impaired Physicians Committee. The next Council meeting has been scheduled for January 16, 1988 at the Salina Holidome.

KMS-IPP

The KMS-IPP Statistical Report for the third quarter of 1987 has been completed. Key statistics are as follows:

°Total number of inquiries for information about the IPP: 20.

°Total number of referrals to the IPP: 26 (18 from KSBHA).

°Total number of physicians being monitored by the IPP: 21.

All 26 referrals to the IPP were males with an average age of 48. Specialty types included: internal medicine (3), psychiatry (1), surgery (1), anesthesiology (1), ophthalmology (1), OB-GYN (1), family practice (8), radiology (1), ENT (1), medical student (1), D.O. (1) and R.T. (1). Reported problems included: alcohol abuse only (7), other drug abuse only (7), alcohol and drug abuse (5), sexual misconduct (1), organic brain syndrome (2), depression (1), other psychiatric (1). The average duration of problems was five or more years.

AMA IN WASHINGTON

The AMA has targeted four key issues of prime importance to Medicine that will be brought to the attention of the Senate Finance Committee, which is considering physician payment issues. These are:

- M.D.-DRGs, mandatory assignment or separate fee schedule for RAP physicians (radiologists, anesthesiologists and pathologists). Senate Finance Committee members are urged to oppose imposition of M.D.-DRGs, separate fee schedules for RAP physicians, and any form of mandatory assignment;
- MEI Update. Committee members are urged to support an equal MEI update for both participating and non-participating physicians. The Medical Economic Index regulates increases in Medicare Prevailing Charges. The Congressional Budget Office has estimated that the MEI update factor for January 1988 will be 3.6%, based on a straightforward application of the current formula.
- Inherent Reasonable Cuts. The Committee will be asked to repeal the "inherent reasonableness" controls. Absent that, they should oppose any inherent reasonableness cuts that deviate from procedures laid out in prior reconciliation acts.
- Maximum Allowable Actual Charge (MAAC) Reform. Imposition of MAACs has caused extensive, unintended inequities and distortions in the Medicare physician payment system, including unjustified rollbacks in established physician fees, coding conversion problems and the inability of Medicare carriers to administer the program properly. Short of total repeal of the MAAC provision, the Senate Finance Committee members are urged to make the following revisions:
 - a. Base each physician's MAACs on his/her own current established customary charge profile; i.e., actual charges submitted from July 1, 1985 through June 30, 1986;
 - b. Provide physicians with access to MAAC information in a timely fashion for making future participation decisions;
 - c. Make the proposed changes in the MAAC methodology retroactive to January 1, 1987 to avoid penalizing physicians for the failure of carriers to provide accurate and timely information and for the flawed methodology determining MAACs.

HIV LAB TEST RESULTS IN MEDICAL RECORDS

KMS legal counsel has issued an opinion stating that HIV lab results should be recorded in a patient's medical record. Regardless of whether the test was performed in a hospital or a physician's office, the test results must be placed in the record. The patient must be aware that the lab results are in the record so that any subsequent consent to the release of the record is an informed consent. For a complete copy of the legal opinion, please contact the KMS office.

EXEMPT LICENSES

On October 10, the State Board of Healing Arts conducted a public hearing on proposed regulations to govern exempt licenses. These licenses were authorized by the 1987 Legislature for retired physicians who are willing to volunteer medical services. The exemption pertains to normal requirements for liability insurance and participation in Health Care Stabilization Fund coverage.

The Board received letters from Lt. Governor Jack Walker and the Association of Osteopathic Medicine, as well as the Kansas Medical Society. A KMS representative was the only conferee to testify publicly during the hearing. Concerns were expressed regarding two regulations.

KMS opposed the section of the regulations which would prohibit exempt licensees from writing prescriptions. It was stated that this could create a hardship for certain patients and would contradict the legislative goal of providing greater access to medical care for persons who otherwise would be underserved.

The testimony also included an objection to a regulation that would require exempt licensees to provide notice to patients that the physician is limited in the scope of medical practice and not insured by the Health Care Stabilization Fund. It was stated that this notice requirement would be awkward and unnecessary.

Following the hearing, the Board briefly discussed the regulations, particularly in regard to authority to prescribe drugs. A motion was adopted to refer the matter to a committee for further study.

AMA HOUSE OF DELEGATES

The 1988 interim meeting of the AMA House of Delegates will be held in early December. Now is the time to contact your Kansas AMA delegates with your opinions on the issues. They are: Jimmie A. Gleason, Topeka; Warren E. Meyer, Wichita; Lew W. Purinton, Wichita; Alex Scott, Junction City; Linda D. Warren, Hanover; and Kermit G. Wedel, Minneapolis.

PROFESSIONAL PATIENT

KMS has received information regarding a patient in the Kansas City area who is obtaining multiple prescriptions for Halcion, Librium and Xanax. She is a female Caucasian, born 10/1/54, who uses the names Jeanne Kathleen Hart, Jeanne Kathleen Sands and occasionally Jeanne Kathleen Kroenig. A former heroin addict, her current complaints are insomnia and stress due to marital problems.

KMS IN ACTION

The KMS Executive Office recently distributed to its component medical societies model bylaws and articles of incorporation. Soon to be distributed to all members will be a physician's Guide to Kansas Law, a reference manual regarding current state laws on a variety of subjects (from abortions to worker's compensation) that may be of relevance in a medical practice. One copy of each document is provided at no charge. For additional copies, KMS members please remit a mailing charge of \$5.00 (cost to non-members is \$10).

The Five-Session Quit-Smoking Clinic

A Smoking Cessation Program Developed At the KUMC Department of Family Practice

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Abstract

Cigarette smoking is a common behavior which has specific, serious health consequences. Family physicians are in an ideal position in the health care delivery system to detect and intervene in this behavior. Most physicians, however, feel ill-equipped to teach smoking cessation techniques to their patients. This paper describes a five-session smoking cessation clinic developed at the University of Kansas Department of Family Practice. The clinic utilizes counseling, patient education, aversive behavioral techniques and nicotine resin chewing gum. These techniques can be taught to and used by family physicians for effectively helping their patients to quit smoking.

CIGARETTE SMOKING has been linked to some of the leading causes of preventable disease in the United States today.¹ Most primary care physicians believe that the most important health-promoting behavior the average person can employ is to refrain from cigarette smoking. In fact, 75% of physicians agree that health professionals should try to persuade their patients to quit smoking.² More than 90% of primary care physicians routinely ask patients about their smoking behavior; however, only 58% consider themselves "very prepared" to counsel patients for smoking cessation, and only 3% consider themselves "very successful" at helping their patients to make changes in their smoking behavior.³ A number of studies confirm that minimal interventions (such as advising patients to quit smoking) show cessation rates greater than control groups, while such advice combined with pamphlets, counseling and follow-up yield even more impressive results.^{4,5,6,7}

The purpose of this article is to present the Five-Session Quit-Smoking Clinic developed at the University of Kansas Medical Center Department of Family Practice. This clinic may be easily adapted for use by family physicians in a university- or community-based practice.

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Description of the Clinic

Administrative Aspects

The Quit-Smoking Clinic consists of five 90-minute sessions held over a four-week period with three to seven days between sessions. This schedule allows participants to examine the principles presented in each session, incorporate new non-smoking behaviors into their lives and return to the group with problems and questions. Participants also complete relevant homework assignments between sessions.

There is a maximum of ten participants in each clinic, resulting in adequate diversity along with individualized attention paid to each member. The fee for the clinic is \$50. This pays for materials provided to participants, and it represents participants' monetary commitment to smoking cessation above and beyond their emotional and time commitment.

The Quit-Smoking Clinic is publicized by posters in the Family Practice Department and announcements in the Medical Center Newsletter and the Family Practice Department Newsletter. Participants are also obtained from referrals from resident and staff physicians within the department. Additionally, new participants are referred by previous or current clinic participants.

Materials supplied include: a consent form for participation in the clinic; a description and agenda, containing the objectives of the clinic, an outline of the techniques used in the clinic and the target date for smoking cessation; a confidential survey which elicits demographic data, smoking history and quitting history and contains questions about the participants' thoughts and feelings about smoking; an American Cancer Society questionnaire entitled "Why I Smoke"; a self-monitoring form; a "contract" to quit smoking; and the American Cancer Society's "Quitting Tips." (Copies of these materials are available from the authors on request.)

Session Summaries

The following sections summarize each session of the clinic. Specific therapeutic strategies and techniques are fully discussed later in this paper.

Session 1: Increasing Self-Awareness. The participants are introduced to the facilitators and to each other. The participants all sign personal contracts, stating simply that they will put forth a maximum effort toward the goal of smoking cessation. Each participant signs two copies; one is kept by the participant, and the other is given to another participant, a close friend or a relative (*i.e.*, a "witness"). The concept of self-monitoring is introduced. As homework, participants monitor their smoking by recording each smoking urge for the seven days until the next session.

Session 2: Preparing for Life as a Non-Smoker. The second session begins with a discussion of the results of each participant's smoking self-monitoring exercise. The family physician leads a discussion about the physiologic effects of tobacco smoke and nicotine with particular attention to participants' questions and concerns. The participants are instructed to begin ridding their homes and work environments of the effects and cues associated with smoking (*e.g.*, gathering cigarettes, ashtrays and lighters, washing upholstery, walls, clothing, etc.). The assignment for the next meeting is to double the number of cigarettes smoked. That is, participants are instructed to smoke two consecutive cigarettes each time they would ordinarily have smoked only one. The immediate negative consequences of smoking (such as irritated throat, excessive time spent smoking, increased monetary cost and cardiovascular effects of high-dose nicotine) are brought into focus by this exercise. The session ends with a reminder that the participants will smoke their last cigarette during the next session, and they are asked to bring their last pack of cigarettes to that session.

Session 3: The Quit Date. This session meets two to four days after Session 2. Participants share insights gained from the increased smoking assignment, discuss their anxieties related to quitting and engage in two aversive smoking techniques: smoke holding and rapid smoking. (These techniques are explained below.) The cigarettes used in these exercises are the last cigarettes the participants smoke.

Immediately following the aversive exercises, participants discuss their reactions to them. Nicotine resin complex gum and its role in smoking cessation are described to participants. A prescription for the gum is given to those who wish to use it. As participants leave this session, they discard all cigarettes and make a public, verbal commitment to total smoking cessation.

Session 4: Support and Problem-Solving. This session meets two to four days after Session 3. The group discusses how they have dealt with urges to

smoke and their current thoughts and feelings, compared to the time prior to the Quit Smoking Clinic. Specific maintenance techniques are discussed which may be substituted for smoking (*e.g.*, exercise, deep breathing and relaxation exercises).

Session 5: Maintenance and Closure. The purpose of the final session is to reinforce long-term maintenance of smoking cessation and to offer closure to the group. The group again discusses their thoughts and feelings about smoking cessation and the strategies which they felt were the most effective in achieving that goal. Participants make a commitment to techniques that they will use to maintain their non-smoking status. Closure of the group is accomplished through discussions about the benefits of the entire experience and plans for a "smoke-free" future.

Discussion of Therapeutic Strategies

There are five major therapeutic strategies employed in the Quit-Smoking Clinic: increased self-awareness; education about the health effects of smoking; aversive techniques; alternative behavioral coping techniques; and nicotine resin complex gum.

These strategies utilize both cognitive and behavioral approaches to smoking cessation. Schiffman⁸ found the combination of cognitive and behavioral techniques (as used in this clinic) superior to the use of either alone for the target behavior of smoking cessation. He also found the use of "willpower" alone to be significantly less effective than the use of formalized, structured cognitive or behavioral techniques. The following sections discuss specific therapeutic strategies incorporated into the clinic.

Increased Self-Awareness of Smoking Behavior

Increased self-awareness is accomplished by completion of a smoking self-monitoring form between the first and second sessions, as well as by group discussions of personal experiences with smoking.

Participants are given several copies of the smoking self-monitoring form and told to record every smoking urge between the first and second sessions of the clinic. The form has columns for recording the time of day, the strength of the urge, participants' thoughts and feelings at the time of the urge and the choice participants made in dealing with the urge (smoking or not smoking). In addition, the American Cancer Society's "Why I Smoke" questionnaire (a series of twenty-one questions about smoking behavior) helps participants elucidate antecedents and reinforcing consequences for the behavior of smoking.

Education About the Health Effects of Smoking

The health effects of smoking are discussed in the second session. A general question-and-answer period is led by the family physician in which he or she responds to participants' specific questions and elaborates on aspects of tobacco use in response to the interests of the group. Emphasis is placed on the physiology of smoking, rather than on pathologic conditions associated with smoking (cancer, lung disease, etc.).

Aversive Techniques

Increased smoking, smoke holding and rapid smoking⁹ are the aversive techniques used in the clinic. Increased smoking (having a second cigarette immediately after the first) makes the experience of smoking less rewarding to the participant. Thus, participants quit smoking with a memory of cigarettes and smoking as quite unpleasant. Smoke holding and rapid smoking link cigarettes with very unpleasant feelings: burning mouth, parched and dry throat, tachycardia, anxiety, nausea, etc.

In smoke holding, each participant swirls cigarette smoke in his mouth until he experiences a burning sensation from the nicotine, or at least 30 seconds. He then blows the smoke through a tissue and examines the tars and residue from partial combustion of the cigarette contents. The group discusses the physiologic implications of their observations and their immediate psychological reactions. In rapid smoking, each participant is instructed to take a full inhalation of smoke once every six seconds until the desire for smoking has ceased or until ten minutes has elapsed. Participants are warned that if they become nauseated or lightheaded, they should voluntarily end the exercise. The safety of rapid smoking has been verified elsewhere.¹⁰

Alternative Behavioral Coping Techniques

As participants quit smoking, they may need alternative coping techniques to substitute for the behavior of smoking. Participants are warned that cigarette urges may continue to occur for weeks, months or longer, and they are encouraged to prepare specific strategies to deal with urges to smoke. In addition to suggestions supplied by participants, facilitators may offer techniques that have been effective for individuals in previous groups, as well as techniques from the research on cigarette smoking and coping.¹¹ Such techniques might include relaxation, exercise, avoidance of stressful situations, diet, etc. All the suggested techniques are discussed, and participants are encouraged to identify and utilize techniques that will work best for them, individualizing therapy as much as possible.

Nicotine Resin Complex Gum

Proper use of nicotine resin complex gum is an ideal physiological and behavioral intervention for participants who choose to use it. Participants are carefully instructed to respond to every smoking urge by using the nicotine resin complex gum. Thus, participants are instructed to substitute an alternative behavior for smoking. Chewing the gum also provides substitute oral gratification that may be a vital part of the cigarette experience for some smokers. Physiologically, the gum releases nicotine, which is absorbed through the oral mucosa.

Conclusions: Smoking Cessation in Family Practice

The negative health effects of smoking are well known to the family physician. Family medicine provides an ideal setting for smoking cessation. The techniques described in the present paper may be used in a group setting; however, they are also easily adaptable for individual patients, with minimal program modification (*i.e.*, reduced group interaction). It is hoped that this clinic will be adapted to other family practice settings in order to further reduce this pervasive health problem.

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Malpractice '87: Status and Solutions

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This is the second of two articles prepared by Dr. Halley to bring to readers a current interpretation of the malpractice situation at both national and state levels. The first appeared in the September issue of KANSAS MEDICINE.

Federal Activity

AT THE FEDERAL LEVEL, there has been increasing interest in medical professional liability, as well as in other aspects of tort reform. The U.S. General Accounting Office (GAO) has recently issued a series of five reports on medical malpractice. The Administration's Tort Policy Working Group, consisting of senior Administration officials from eleven federal agencies, issued its second report in March, updating the group's 1986 report, "The Causes, Extent, and Policy Implications of the Current Crisis in Insurance Availability and Affordability." A number of bills addressing the issue of medical professional liability were considered in the 99th and in the 100th Congress. Several of these proposals are noteworthy, although only the Health Care Quality Improvement Act has become law.

H.R. 1372 and S. 155, two similar but not identical bills, were introduced by Representative Robert Mrazek, and by Senator Daniel Inouye. These bills would provide federal funds for states to establish and operate panels to hear and decide malpractice claims. They would also require states to enact a comprehensive set of tort reforms to qualify for the federal grants.

The Health Care Quality Improvement Act of 1986. Title IV of the Omnibus Health Bill, Public Law 99-660, was signed into law on November 6, 1986. The new law contains important provisions concerning the protection of peer review activities under specified circumstances and reporting requirements for medical malpractice. It requires the reporting of settlements or satisfaction of judgments in medical malpractice cases, disciplinary actions taken by State Boards of Medical Examiners, and specified disciplinary actions against physicians by hospitals or other entities. Such reports are to be made to the Secretary of Health and Human Services (HHS), or to a databank or clearinghouse, as well as to the relevant state licensing boards. Hospitals are required to request any information on file for medical staff members every two years and for all

new medical staff applications. Hospitals may also request information on practitioners who have current or prospective affiliation.

The Medical Offer and Recovery Act of 1985 (Moore-Gephardt Bill) was designed primarily as a model for state legislation. It would have an independent effect on beneficiaries of federal programs, such as Medicare, Medicaid, and federal employee health plans. Under this bill, the provider can offer, within a specified time period, to make periodic payments covering all economic losses caused by adverse results of medical treatment. Non-economic damages and damages compensated by collateral sources are eliminated. The plaintiff is foreclosed from pursuing conventional tort actions once the offer is made, except when the provider intentionally caused the injury or wrongful death occurred. A significant advantage of the bill is the voluntary choice of the provider. Payments would presumably be made only in cases where the probability of plaintiff's recovery is high, and other cases would be resisted in court. Among the objections to the bill has been the concern that this approach might encourage non-meritorious claims and would lead to an increase in claim frequency and thus premium costs.

The Federal Incentives for State Health Care Professional Liability Reform Act of 1985 (Hatch Bill) is based on American Medical Association proposals. This bill would enact a model for state legislation and would provide financial incentives to states enacting reforms described in the model bill. These reforms focus, as do those of Moore-Gephardt, on the limitation of non-economic damage awards and on the elimination of the collateral source rule. Major provisions are mandatory periodic payments of damage awards exceeding \$100,000; mandatory offset of collateral source payments; limitation of non-economic damages to \$250,000; and a sliding scale for limitation of contingent fees. Other provisions cover increased funding for state disciplinary boards and development of risk management programs by hospitals, and encourage peer review for questionable practice patterns.

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An updated version (H.R. 1955) was introduced by Representative Norman Lent in the 100th Congress. This version gave discretion to the Secretary of HHS to award funds to states enacting tort reforms that, although different from those specified in the bill, have a substantial likelihood of achieving the purposes of the legislation.

A study of *Hatch Bill impact*, commissioned by the American Medical Association, raised questions about the long-range effects of these tort reforms. The expected future premium cost savings resulting from the enactment of all four major reforms proposed by the bill were estimated at 28 percent in a typical state. The estimated savings were considerably less if certain assumptions proved incorrect.

Tort Reform Results

The actual effects of legislative changes have been difficult to measure, although insurance problems abated after each round of reforms. Moreover, a striking feature of reforms has been that many were targeted at marginal features of the tort system, where changes seemed unlikely to have important effects on either the frequency or the severity of claims.

An analysis by Danzon³ utilized the data base of closed claims collected by a survey of the National Association of Insurance Commissioners for the period 1975–78, and thereafter used data furnished by several large insurers. The analysis was impaired by the lack of comprehensive and consistent data and by the possible underenforcement of some statutes which were under constitutional challenge.

Claim Frequency was affected only by the following reforms: *Statute of limitation* reduction decreased total claim frequency by 8 percent per year of reduction; *Collateral source offset* was estimated to reduce frequency by 14 percent — laws that simply admitted evidence of collateral sources seemed as effective as laws mandating offset; *Arbitration laws* appeared to increase the frequency of claims filed and claims paid, the impact being greatest for small claims.

Claim Severity was affected only by the following: *Caps on awards* reduced the average severity of claims by 23 percent; *Collateral source offset* appeared to reduce awards between 11 and 18 percent — significance levels were higher for mandatory than for discretionary offset; *Arbitration statutes* appeared to decrease average claim severity, probably due to the increased frequency of smaller claims.

No other reform analyzed, including screening panels and limits on contingent fees, had a significant effect on either frequency or severity of claims.

Alternative Solutions

Solutions other than tort reform continue to be studied, but are not sufficiently developed or have not gathered sufficient support for implementation. These efforts can be grouped into three categories: (1) “Neo-no-fault” plans, which do not contemplate total displacement of the tort system, but which hope to broaden the availability of automatic indemnification for net economic loss. A recent proposal contemplates implementing offer-recovery mechanisms as in Moore-Gephardt by private initiative through insurance for specified injuries.⁴ Other proposals involve no-fault maloccurrence insurance based on designated compensable event schedules which would provide automatic compensation for specified adverse outcomes.⁵ (2) Enforceable private contractual agreements between the parties for risk allocation or for dispute resolution.^{6,7} (3) Binding arbitration agreements between providers and possible claimants. (4) Total replacement of the tort system by a patient compensation system, using as models the workers’ compensation systems functioning successfully in every state, as well as the medical injury compensation systems of Sweden and New Zealand.^{8,9}

Proponents of the compensation approach contend that tort revision will not be successful, and that a workable administrative compensation system will be the ultimate solution, although available data indicate that a larger number of injuries must then be identified and compensated.¹⁰ A previously completed statutory prototype, analogous to workers’ compensation laws,¹¹ has been revised and expanded into a comprehensive model statute for a medical accident compensation system.¹² In its present form, the model appears to address effectively all major issues, including definition of the compensable event, the handling of claims, dispute resolution, funding, payment of compensation, ongoing evaluation through data analysis, health-care quality control, cost, and constitutionality. The model is inherently flexible in that individual provisions can be changed if desired or if required by actuarial evaluation. Although it is based on Kansas statutes, the entire document is easily adaptable to other jurisdictions.

The framework of the compensation system consists of a full-time state compensation board supported by expert review panels, the state court system, a quality-control mechanism, and a data base section. *The Medical Accident Compensation Board* consists of a director and two associate directors, assisted by one or more administrative law judges. The Board approves settlements and promptly hears

and decides claims for preliminary or final compensation in the form of medical benefits, rehabilitation benefits, temporary or permanent personal injury benefits, or death benefits. Board decisions may be reconsidered administratively, or may be appealed to the court system as discussed below. *Expert review panels* consist of one, two, or three qualified providers. The panels are convened if necessary to assist the Board in the evaluation of claims. Although Board determinations may be made without a panel opinion, the Board is mandated to utilize such panels liberally and to consider panel conclusions strongly persuasive in determining the presence or absence of injury, the presence or absence of substandard practice, and the presence or absence of causation of such injury by substandard practice. *State district courts and appellate courts* hear and determine appeals from Board decisions within the purview of the act. The courts must act expeditiously by giving preference to the consideration of compensation cases, and may approve, reverse, or modify Board decisions. *Quality control*, separated from compensation, occurs through mandatory reporting of all claims and outcomes, as well as information from the data base, to state licensing agencies, the state department of insurance, or to hospitals or other organizations for evaluation and appropriate action. Such action may take the form of notification or educational contacts, insurance rating or withdrawal of insurance coverage, or may result in sanctions involving hospital privileges or provider licensure. *Database* is a special section of the Board for continuous collection and processing of all data concerning health care injuries. The database section monitors the overall effectiveness of the compensation system; provides and publishes statistics, information, and analysis for quality control or risk management; and assists in the study of prevention, occurrence, and compensation of health-care injuries.

The model statute defines compensable personal injury as impairment, disability, or other adverse outcome caused by substandard health care practice, arising out of the delivery or the failure of delivery of health care to a patient. The model provides unlimited medical and chronic care benefits, specified rehabilitation benefits, and burial expenses. Personal injury and death benefits for workers or retired persons are based on the patient's actual or constructed spendable take-home earnings, limited to 75% of the state's average weekly wage. Similar benefits for minors, housewives, and homemakers are provided at 75% of the state's average weekly wage. Death benefits are limited to \$200,000, with

exceptions for payments to dependent children; permanent total disability benefits are limited to \$125,000; and temporary or permanent other injury benefits are limited to \$100,000. Such limits are presently provided in comparable workers' compensation statutes.

The cost of compensating a larger number of injured patients through an administrative compensation system continues to be a major concern. However, this concern appears less formidable when viewed against the background of steadily increasing costs of compensating a relatively small number under the present system. The additional expenses are offset in part by the greater efficiency of an administrative system, which will permit a larger percentage of the insurance premium to be available for payment of benefits.

Cost control is further achieved by the following provisions, most of which are currently utilized by workers' compensation programs: self-insurance for injuries not caused by substandard practice; reasonable statutes of limitation for the filing of claims; payment only for medical care, rehabilitation, and economic loss; limitation of total awards as previously noted; periodic payments of awards; provisions to modify or terminate benefits for change in physical condition of a patient, remarriage of a spouse, or death or marriage of a dependent child; offset of private or other medical or disability insurance; offset of life insurance at least to some degree; an entry threshold, providing benefits only if an injury persists for one week or longer; limitation of attorney fees to the lesser of a reasonable amount or 25% of compensation paid; and perhaps some utilization of scheduled awards. Provider financing is considered feasible under the above provisions. A broader base of financial support would probably be necessary if cost-control mechanisms are omitted, or if benefits for additional injuries are contemplated.

The constitutionality of a medical accident compensation system is another concern and cannot be definitely predicted. This was the case with workers' compensation, where early statutes were struck down, but subsequent enactments have been universally upheld when they were deemed to be consistent with changing social values. The ultimate determinations for an administrative compensation system should be favorable, since social need is apparent, and since the proposed changes in common law rules are balanced by expeditious, fair, and certain benefits for a larger number of injured patients, many of whom receive no compensation under the present system.

Conclusions

Tort reform legislation has again supplied the short-term solution for crisis. The reforms have been accompanied by provisions for injury reduction through patient safety programs, risk management, and loss prevention programs. There has also been an upsurge of medical regulatory and disciplinary legislation mandating peer review, continuing education, incident reporting, expansion of licensing board authority, and attention to impaired or incompetent physicians. Measures other than tort reform, however, although beneficial for other reasons, do not impact the bulk of the professional liability problem and cannot be expected to affect it significantly.

The question must be asked whether the tort system can in reality be revised to function appropriately for health care or for society generally. There is widespread agreement that the system has failed in its major objectives of compensating injury and deterring substandard practice. For compensation, the system undercompensates many, while overcompensating a few; it is slow, uncertain, and expensive; it fosters adversarial relationships; and it can be characterized as a "legal lottery." For deterrence, there is no objective evidence that the threat of potential litigation prevents health care injuries; there is no evidence of adverse effects upon the number of injuries or upon quality of care when replacement of the system has occurred. For revision, the long-term effects of reforms are at best uncertain, and will perhaps be trivial.

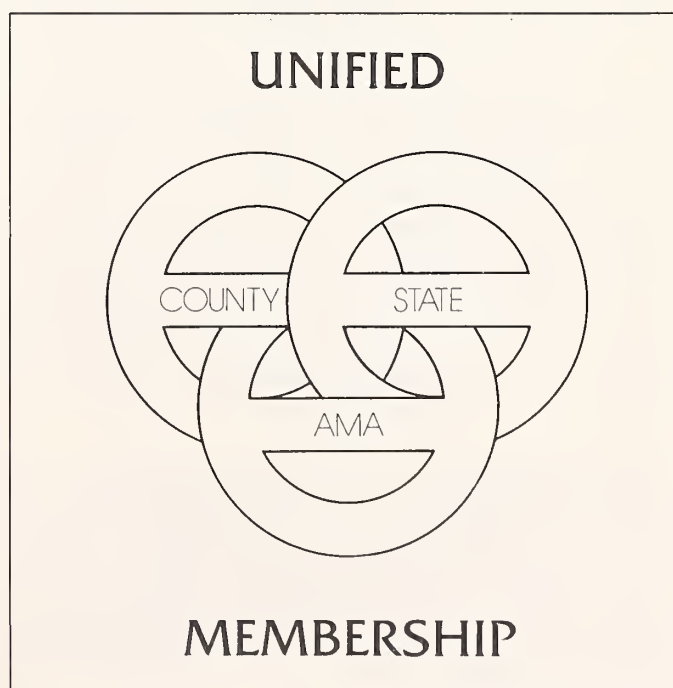
Finally, it must also be recognized that the thrust of tort reform has been insurance cost reduction and maintenance of the liability insurance market. Other effects, however, have also occurred, some hostile to consumers. Specifically, for the injured patient, reforms make recovery more difficult, and decrease the compensation finally obtained. The ultimate analysis of costs and benefits must critically evaluate such consumer-hostile solutions which permit the delivery of care, but continue undesirable features of the present system.

Certain conclusions and recommendations appear appropriate: Patient injuries must be minimized; therefore, programs for patient safety, professional and public education, and quality assurance are essential. Adequate data are critical for analysis and decision-making; therefore, development of and access to a comprehensive data base are imperative. Tort reform has demonstrated some beneficial short-term and intermediate effects; therefore, reforms should continue to be supported, at both state and federal levels. Long-term effects of tort reform, however, are uncertain; therefore, continued effort

is required in the evaluation of alternative solutions for this complex problem. A field trial of an appropriate administrative compensation system appears warranted.

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MEDICINA ET LEX

The Liability of Drug Manufacturers and Physicians

WAYNE T. STRATTON, J.D.,* *Topeka*

IN TWO recent decisions, the Kansas Supreme Court has discussed the liability of drug manufacturers and physicians for adverse consequences arising from the administration of a drug. These cases deserve discussion.

In one case, the court upheld a judgment for compensatory and punitive damages awarded a plaintiff who developed hemolytic uremic syndrome from the use of Ortho-Novum 1/80, manufactured by the defendant. The issue before the court was whether the defendant manufacturer had a duty to warn of an association between the use of the product and HUS. The court held that the manufacturer of a drug has a duty to make timely and adequate warnings to the medical profession of any dangerous side effects produced by its drugs of which it knows, or has reason to know.

The court considered the patient's doctor to be a learned intermediary between the purchaser and the manufacturer. If the doctor is properly warned of the possibility of a side effect in some patients, and is advised of the symptoms normally accompanying the side effect, the court concluded that there is an excellent chance that injury to the patient can be avoided. The court quoted language from another case which held that "it is a physician's duty to inform himself of the qualities and characteristics of those products which he prescribes for or administers to or uses on his patients, and to exercise an independent judgment, taking into account his knowledge of the patient as well as the product. The patient is expected to and, it can be presumed, does place primary reliance upon that judgment. The physician decides what facts should be told to the patient. Thus, if the product is properly labeled and carries the necessary instructions and warnings to



Mr. Stratton's discussion topics are selected for their medicolegal interest to physicians. Readers are invited to submit questions or items of interest in this area for attention in this series.

fully apprise the physician of the proper procedures for use and the dangers involved, the manufacturer may reasonably assume that the physician will exercise the informed judgment thereby gained in conjunction with his own independent learning, in the best interest of the patient. It has also been suggested that the rule is made necessary by the fact that it is ordinarily difficult for the manufacturer to communicate directly with the consumer."

Recently, the court decided a case in which the plaintiff developed bulbar paralytic poliomyelitis following the administration of an oral polio vaccine by a pediatrician to his infant daughter. The physician was a defendant in the action; however, the jury determined that he was not liable for any negligence.

A \$10,000,000 compensatory and punitive damage award was reversed by a sharply divided supreme court, the majority concluding that the warning given by the manufacturer was sufficient because the product was an unavoidably unsafe product within the meaning of the Restatement of Torts.

*KMS Legal Counsel.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE, or the Kansas Medical Society. For further information, contact Mr. Stratton, 215 E. 8th, Topeka KS 66603, 1-800-332-0248.

In their dissent, three members of the court expressed a philosophy which is somewhat alarming for physicians. They said:

In situations where a product is sold and delivered to a treating physician, who then administers the product to the patient, the law requires that the manufacturer of the drug provide information and a sufficient warning to the physician who in turn is required to advise the patient or user of a drug of its dangers so that the ultimate user may make an informed decision whether to expose himself or herself to it.

At a later point in the dissenting opinion, the following statement appeared:

The cases hold that the ultimate consumer is entitled to this information as a matter of law so he can make an informed decision whether to expose himself to it. The majority opinion does not dispute that principle. If the warning was sufficient as a matter of law to convey the dangers and alternatives involved to the physician, and the physician did not convey that information to the plaintiff, then it would logically follow that the physician is liable for failure to carry out his duty to give the required warning to Mr. Johnson.

Kansas law, as developed over the last quarter of a century, recognizes that a physician may be responsible for injuries occurring as a result of the failure to give sufficient information for a patient to make an informed consent to treatment. The extent of this warning, however, has always been measured by the practices followed by physicians in the community or in similar communities. Kansas law has never imposed an absolute requirement to warn a patient of all possible risks and hazards associated with the treatment.

This is particularly significant in the polio vaccine case. In this case, the evidence was that the possibility of developing bulbar paralytic poliomyelitis was approximately one in a million. It is unlikely that many physicians would feel it necessary to warn a patient of every conceivable adverse effect of a medication, no matter how remote.

In fairness to the minority of the court, the issue of the liability of the physician was neither briefed nor argued, and if the issue is presented, one hopes that the court will follow the language of the *Ortho Novum* case. Physicians, however, must be aware of the special position which they occupy as an informed intermediary to convey information regarding the risks of certain drugs to their patients.



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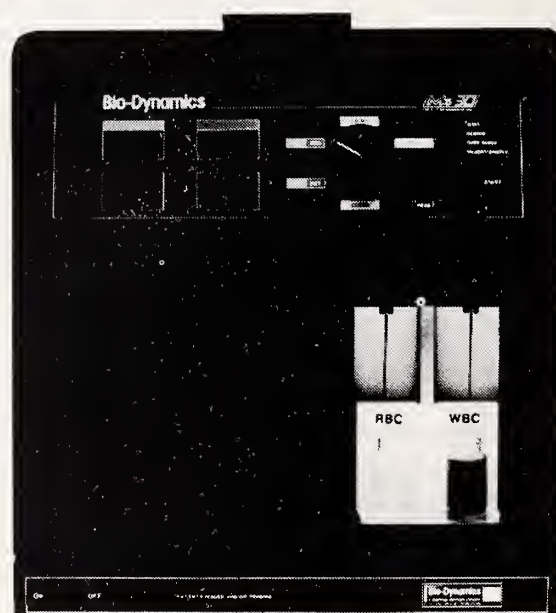
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Tort Reform

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SUE THY NEIGHBOR seems to have become the American substitute for love thy neighbor. Fourteen million of us filed suits in 1986. The most dramatic indication of our propensity to reach for a lawyer is a comparison with Japan. We sue about 20 times as often as the Japanese. There are some special reasons for that, but there is no doubt they place a higher value on social obligations and that we pay a high price for pushing our adversarial tendencies to the extreme. The cost of the 1,000,000 tort cases decided here in 1986 was between \$30 billion and \$37 billion. That's a troublesome inflater of liability-insurance costs for business, health-care providers and state and local governments. Perhaps no one in our individualistic society will shed tears for such big defendants, but the individual suffers in the end.

Nervous companies are withdrawing from risk enterprises such as the manufacture of vaccines and drugs. Local governments are canceling recreational programs for children. Doctors are leaving medicine because they cannot afford malpractice insurance. Otis Bowen, Secretary of Health and Human Services, released a government study on malpractice showing that insurance premiums for the average doctor had jumped 81 percent from 1982 to 1985, while increasing 113 percent for the hardest hit specialty, obstetrics and gynecology. Physicians are simply shunning procedures associated with malpractice suits. In one city, doctors refused to deliver any baby whose parent was a lawyer until something was done to limit malpractice liability. In Florida, a woman who was shot in the back waited 13 hours before doctors could find a hospital or a neurosurgeon unafraid of a malpractice lawsuit.

Many agree that tort reform is the answer and are demanding legislation to curb the excesses. Proposals include: Limiting the plaintiff's award for pain and suffering; deducting the amount a plaintiff receives from his own insurance from what the defendant must pay; limiting contingent fees for plaintiffs' lawyers to curb the incentive for lawyers to press for litigation.

(Continued on page 303.)

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TORT REFORM (Continued from page 301.)

There are certainly glaring abuses. Everyone can cite cases that illustrate absurd results in tort litigation. There are too many sham plaintiffs, with their complaints of lower-back pain and emotional anguish in every accident, who sue on the calculation that defendants will want to avoid the cost of litigation. On the other side, consumer and bar groups point out that the system is already stacked heavily in favor of defendants because they have more money, legal help and time than individuals who get exhausted, mentally and financially, and settle for ridiculously low sums.

The issue is how the tort system should be reformed. The problem lies in the question of fault. Fault, the ancient basis of the tort system, is a concept that antedates the Industrial Age. Before machines, it was always clear who injured whom and how. Now, complexity has clouded fault in technological mystery and ambiguity. Both sides can marshal legions of scientific experts to establish fault. The result is that trials drag on for years and are outrageously expensive.

We need to remove fault from the product-liability and malpractice area of tort law. We need no-fault systems to guarantee compensation to the injured in predictable amounts. Plaintiffs would not be forced to wait for years. Defendants would benefit, too. They would not be subject to the roulette-wheel justice of juries and their arbitrary verdicts.

If Japan provides a philosophical point, New Zealand provides a practical one. It has most thoroughly replaced a litigation policy with a social policy. Nearly all actions for damages from accidents have been abolished. Everybody in New Zealand is covered so that, in the event of an accident, there is swift and sure compensation for medical treatment, loss of earnings, pain and loss of a wage earner through death. The money comes from funds supplied by regular contributions from employers, holders of drivers' licenses and money appropriated by Parliament.

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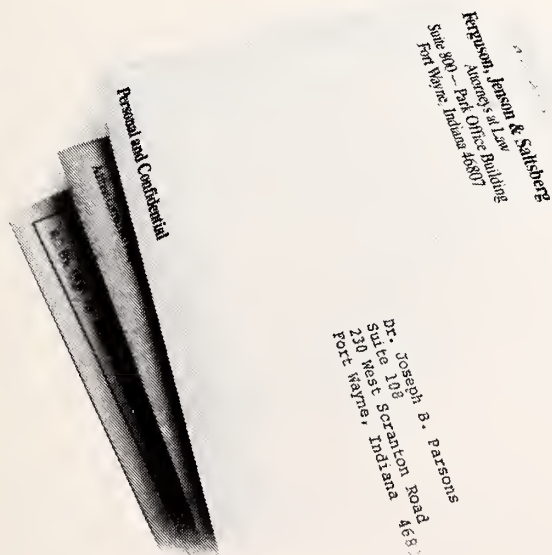
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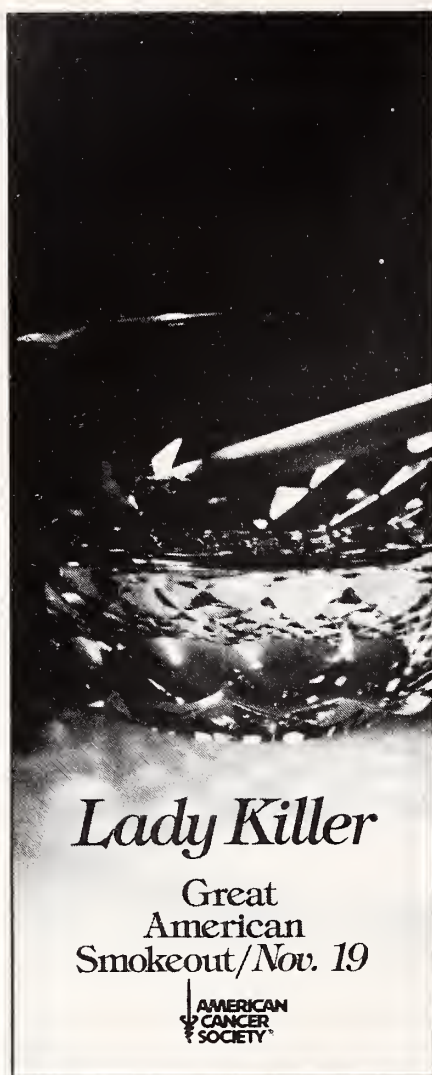
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Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring

reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects at both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt). Available in bottles of 100 and 500, Tel-E-Dose[®] packages of 100; Prescription Paks of 50.



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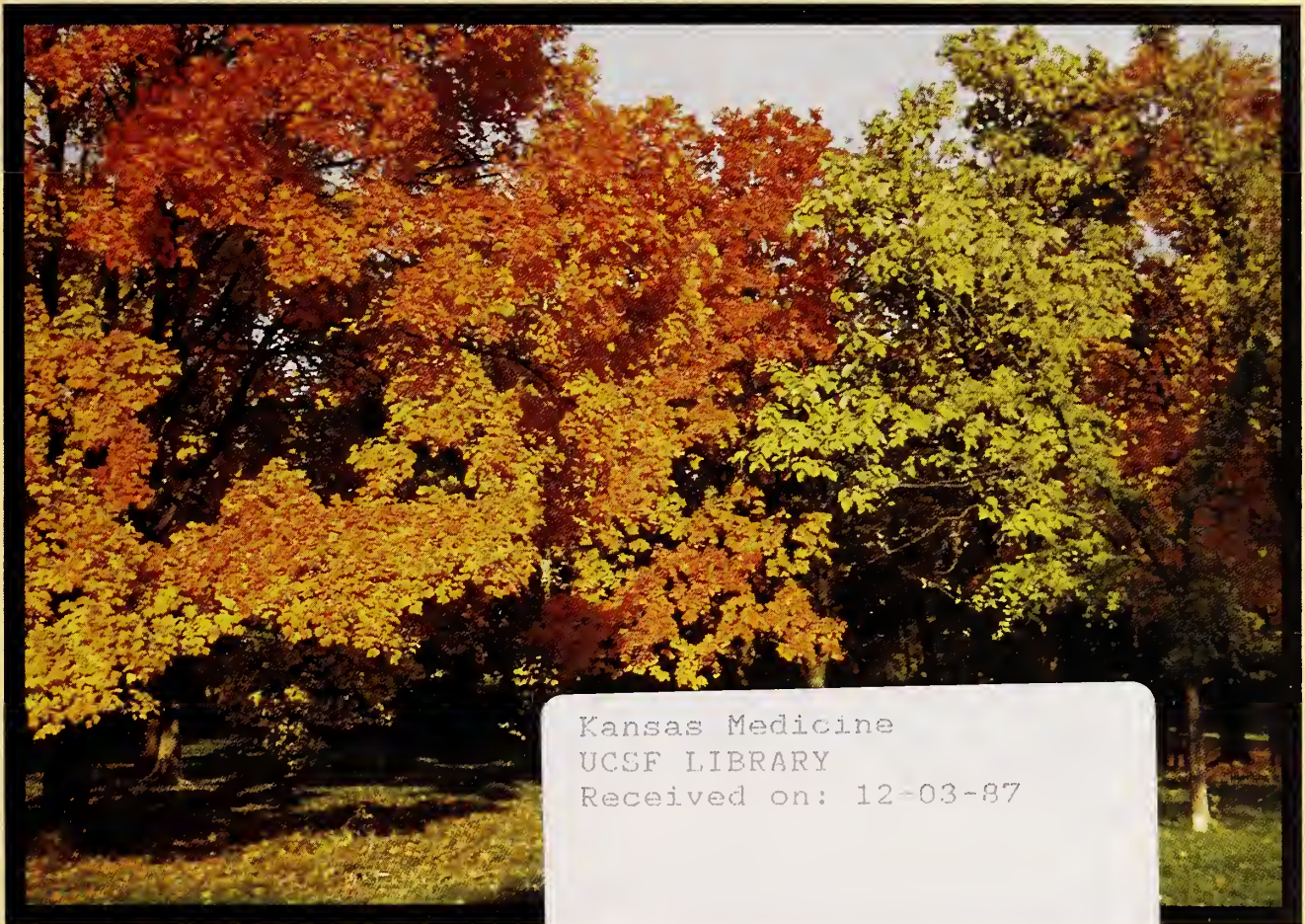
Each tablet contains 10 mg clordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) ^{IV}

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Please see summary of product information on adjacent page.

KANSAS MEDICINE

Volume 88, Number 11, November 1987 ISSN 8755-0059



Scientific Articles

Surfactant Supplementation Trial: Interim Analysis	314
Idiopathic Thrombocytopenic Purpura in Children	317
KMS Newsletter	316a

THE JOURNAL OF THE KANSAS MEDICAL SOCIETY



KANSAS MEDICINE

• The Journal Of The Kansas Medical Society •

Volume 88, Number 11, November 1987

Contents

Scientific Articles

Surfactant Supplementation Trial: Interim Analysis

- Barry T. Bloom, M.D., Wichita 314
*A study of human and bovine surfactant use for the
treatment of respiratory distress syndrome in preterm
infants*

Idiopathic Thrombocytopenic Purpura in Children: New Therapeutic Considerations

- Abbas Emami, M.D., Robert C. Trueworthy, M.D.,
and Tribhawan S. Vats, M.D.,
Kansas City, Kansas 317
The diagnosis and management of ITP in children

Miscellaneous

- Classified Advertisements 330
Cover Story 305
Editorial Comment 310
Information for Authors 308
KMS Newsletter 316a
Medicina et Lex 320
New Tax Law: Hidden Effects on
Life Insurance Policies 324
Physician Directory 327
President's Message 312
Public Affairs Staff Added at KMS 306
To Help a Sick Friend 322

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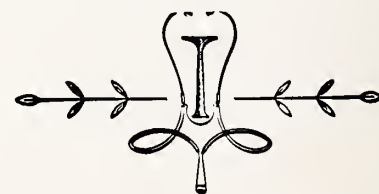
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Cover

This photo of trees in Gage Park, Topeka, was taken with an Exacta 35mm camera, using Kodachrome film at F8 and 1/60 sec.

AUTUMN HAS no more distinctive hallmark than the turning of the leaves, as represented by Chet Lessenden's cover photograph. The resulting colors have inspired artists and poets for many years, though the pragmatic householder finds the enjoyment of such beauty somewhat tempered shortly thereafter when it becomes necessary to dispose of the leaves that have decided to come down to earth.

The combination of fact and territorial promotion has made New England the champion in attracting people from across the nation to come and view their annual production, inspiring not only the poets and artists but the well known canny New England merchants. Inevitably, then, that area has become the source for some facts regarding the ubiquitous leaf, for which we are indebted to *Yankee* magazine. If you have apple trees, you can expect an average one to produce 100,000 leaves. The oak, however, comes up (or off) with 700,000, while a mature American elm gives off 5,000,000. (Did you doubt it?) A tree nine inches in diameter will account for six pounds of fresh leaves, but when they are dry, they weigh in at only two and a half. New Englanders have at least 72 billion leaves falling from their trees each year, a figure we probably can't compete with — regardless of local feelings. Consider, though, that disposing of theirs requires 416,000,000 dump-truck loads of eight cubic yards each.

True to the local spirit, one Yankee village bales and sells its accumulated leaves at 40 cents a bushel. *Yankee* avoids saying what use one might have for baled leaves, but they probably sell them to susceptible visitors from other parts of the country. — D.E.G.

**Please address letters for
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c/o Kansas Medicine
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FAMOUS PHYSICIANS ARE SHOWING UP FOR OUR 40th YEAR CELEBRATION.



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Roy J. Gerard, M.D.
Joseph A. Scoma, M.D.
Eugene P. Salvati, M.D.
Richard A. King, M.D.

Read Every Issue From Cover to Cover:

October

Symposium: Allergy Richard D. deShazo, M.D.
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November 1

Symposium: Focus on Family Practice Roy J. Gerard, M.D.
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November 15

Symposium: Colon & Rectal Disease Joseph A. Scoma, M.D.
Coordinator

Special Article: Colon & Rectal Disease 1947-1987 Eugene P. Salvati, M.D.

December

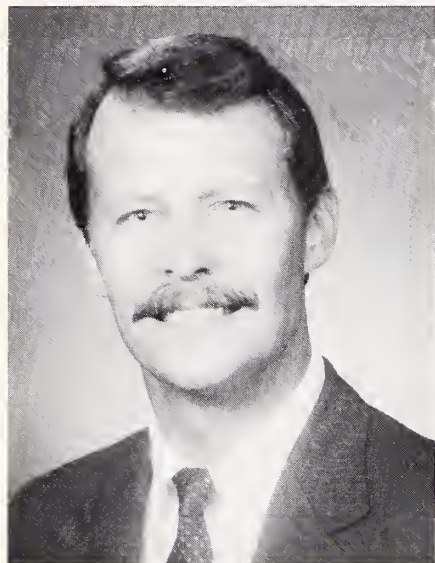
Symposium: Genetic Diseases

Special Article: Genetics 1947-1987 Richard A. King, M.D.

40-YEAR
**Postgraduate
Medicine**

Every Issue is a Celebration of Clinical Information

Public Affairs Staff Added at KMS



Chip Wheelen

THE KANSAS MEDICAL SOCIETY recently appointed Charles L. "Chip" Wheelen to the position of Director of Public Affairs. Chip began performing his new duties October 1.

KMS Executive Director, Jerry Slaughter, and KMS President, Dr. Donald Hatton, selected Chip from a group of well qualified candidates because of his years of experience working with the Kansas Legislature. Prior to joining the Medical Society staff, Chip was employed by the lobbying firm Pete McGill and Associates. He worked there for approximately four years, representing a variety of clients with interests in numerous issues.

Before becoming a lobbyist, Chip was a staff member in the Kansas Legislative Research Department. He served in that capacity for almost four years after receiving a Master of Public Administration degree from the University of Kansas.

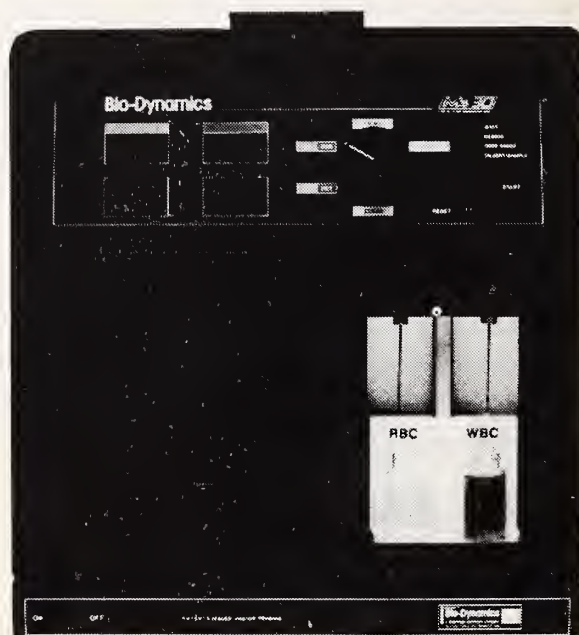
A native Kansan, Chip grew up in Winfield and received a Bachelor of Arts degree from Wichita State University. After graduating from WSU, he served three years of active duty as an officer in the Navy.

Chip and his wife, Nancy, are proud parents of a sixteen-month-old daughter. They reside in Topeka.

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Brief, concise **articles** are preferred; an ideal manuscript will not exceed five double spaced pages. All material will be edited by the staff copy editor to assure clarity, good grammar and appropriate language, and to conform to KANSAS MEDICINE style and format. When feasible, material may be condensed.

The **author** will be asked to review the galley proof prior to publication to verify statements of fact. Although editing and proof-reading will be done with care, the author is responsible for accuracy of material published.

The **galley proof** is for correction of ERRORS; rewriting of material must be done prior to submission. Authors are urged to carefully check manuscripts and galley proof for errors that could result in inaccurate information.

Drugs should be referred to by generic names; trade names may follow in parentheses if useful. All **units of measure** must be given in the metric system.

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BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Paks of 100. The tablets are embossed with MARION/1712.

Issued 3/84

References:

1. Grossman MI: *Scand J Gastroenterol* 58 (suppl 15):7-16, 1980.
2. Marks IN, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly*. Edinburgh, Churchill Livingstone, 70-81, 1984.
3. Krentz K, Jablonowski H, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly*. Edinburgh, Churchill Livingstone, 62-69, 1984.



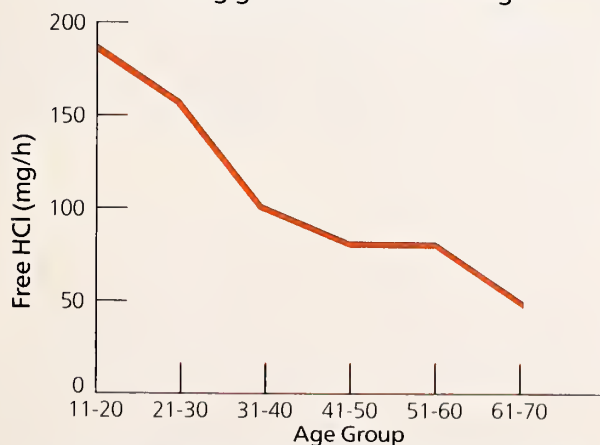
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If your duodenal ulcer patient is over 55, decreased mucosal resistance is more likely to cause an ulcer than hypersecretion of acid-pepsin.¹ A tendency toward lower acid secretion with advancing age has been shown.^{2,3}

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The unique, nonsystemic action of Carafate enhances the body's own ulcer healing ability, strengthening the mucosal structure as it protects damaged tissue from further injury.

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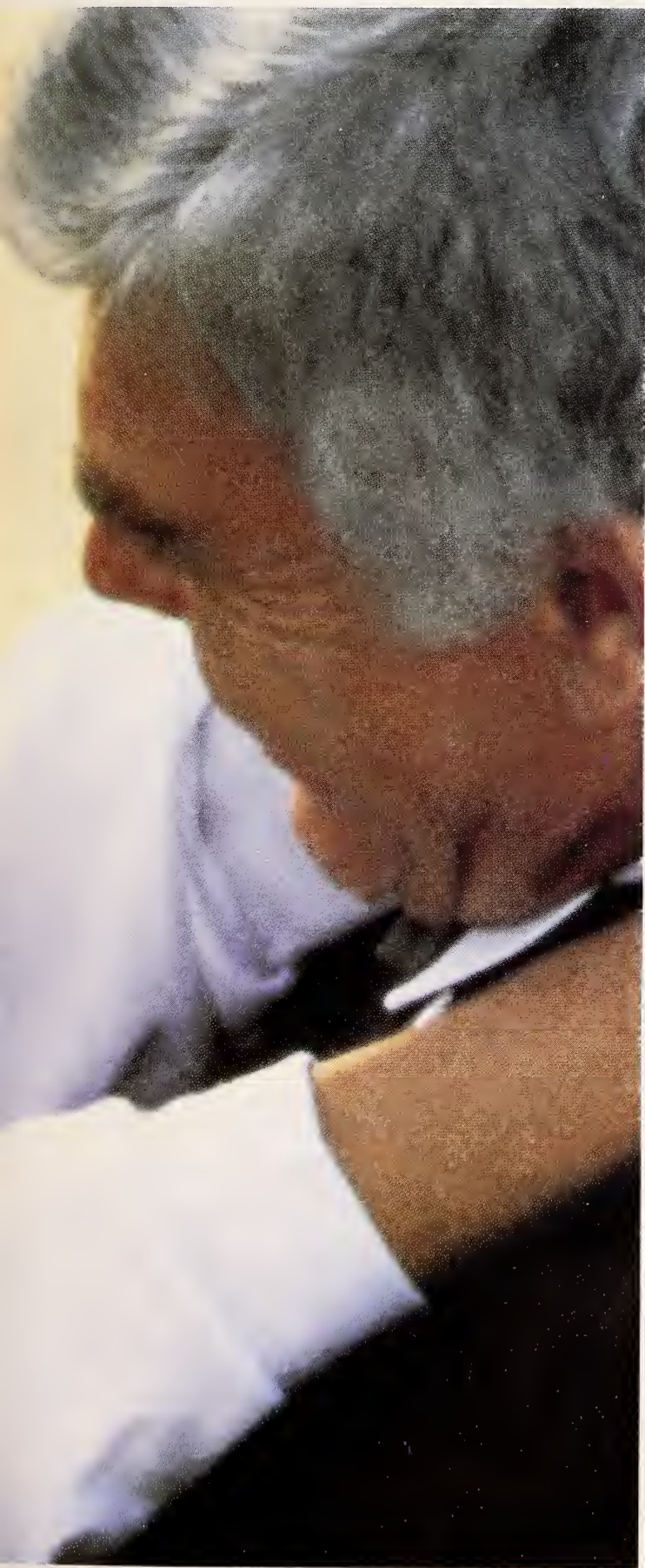
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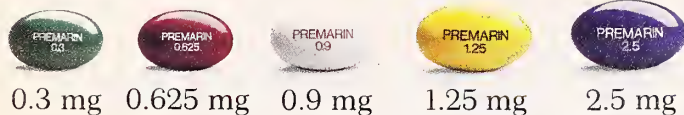
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*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary
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For moderate-to-severe vasomotor symptoms and for osteoporosis

PREMARIN® (conjugated estrogens tablets)



The appearance of these tablets is a trademark of Ayerst Laboratories.

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)

PREMARIN® Brand of conjugated estrogens tablets, USP

PREMARIN® Brand of conjugated estrogens Vaginal Cream, in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA. Three independent, case-controlled studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case-controlled studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semi-annual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equi-estrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY. The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing, in later life, a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case-controlled study estimated a 4.7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17 α -dihydroequilin, together with smaller amounts of 17 α -estradiol, equilin, and 17 α -dihydroequilin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe vasomotor symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (see Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Estrogens have been reported to increase the risk of endometrial carcinoma (see Boxed Warning). However, a recent large, case-controlled study indicated no increase in risk of breast cancer in postmenopausal women. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

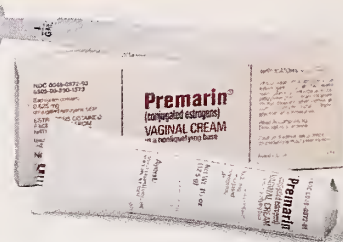
Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

For atrophic vaginitis

PREMARIN® (conjugated estrogens)

Vaginal Cream

0.625 mg/g



Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Pre-existing uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not yet complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

- Increased sulfobromophthalein retention.
- Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.
- Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T_4 by column, or T_4 by radioimmunoassay. Free T_3 resin uptake is decreased, reflecting the elevated TBG; free T_4 concentration is unaltered.
- Impaired glucose tolerance.
- Decreased pregnanediol excretion.
- Reduced response to metyrapone test.
- Reduced serum folate concentration.
- Increased serum triglyceride and phospholipid concentration.

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. However, in a recent, large case-controlled study of postmenopausal women there was no increase in risk of breast cancer with use of conjugated estrogens.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis; change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DDSAE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate-to-severe vasomotor symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 mg to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically:* Osteoporosis. Female castration. Osteoporosis — 0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off). Female castration — 1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three- to six-month intervals.

Usual dosage range: 2 g to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

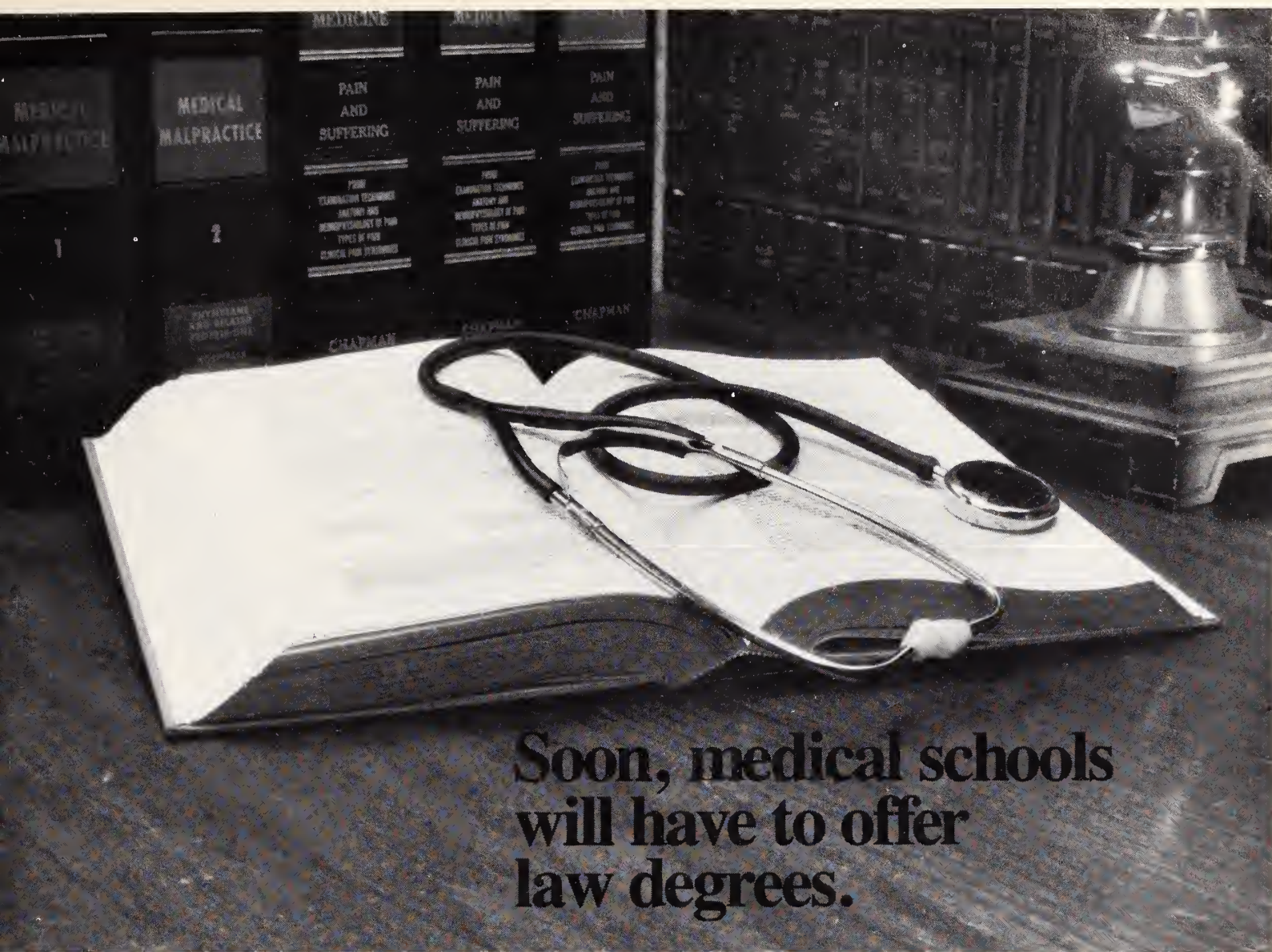
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EDITORIAL COMMENT

Mens Sana in Corpore Sano, We Hope

HARRY SCHWARTZ, PH.D., well known as an observer of the medical scene, commented in *American Medical News* regarding the disparity in health care accorded to certain individuals high on the social or political scale, as compared with those not so favored. His focus was on Mayor Ed Koch's recent experience with transient cerebral ischemia relative to that of a hypothetical patient of lesser stature.

Dr. Schwartz is aware, of course, that the King has always received preferential treatment as compared with Everyman. Physicians involved knew that their pockets might be filled with gold if they were lucky with the King, but the beheader's ax awaited failure. Caring for Everyman might not have been as lucrative, but it was easier on the nerves.

The matter is of particular interest as we go into the quadrennial frenzy of electing a new president. Both public and aspirants are advised to keep in mind that being President of the United States means that when he (or she) sneezes, the world says, "Bless you" (albeit with differing shades of sincerity, depending on the origin). Even a casual glance at the history of the Presidency points out that the incumbent's health (or, rather, lack of it) has, at some point, become a matter of concern in most cases. It has been suggested that a Presidential Commission be formed to manage such matters, which is immediately an invitation to speculation about the purpose and function of such a group. We presume it would pass on the respective physical and mental health of the candidates and watch over the incumbent to see that the necessary care was given without an overlong stint in the waiting room.

At the moment, the Presidential health seems the prime example of abdication of privacy. The media see to it that we get the news, the diagrams and the opinions of various non-involved experts (under contract to the networks) before the receptionist gets the forms filled out. The institution and staff chosen would, we hope, represent the President's choice but probably have mixed feelings: enjoyment of the

honor, annoyance at media demands and a certain trepidation as to the outcome, considering the tendency for medical matters to go agley in the best of circumstances. Those not chosen undoubtedly feel some chagrin at the oversight — eased by the relief of avoiding the disagreeable features of the event. At the moment, it seems the President's greatest risk is getting too much care (or appearance thereof).

Avoiding exposure of the electorate to physically or mentally unsuitable candidates seems pretty well taken care of at the moment, though not on the loftier planes of statesmanship. It has already been demonstrated that the media and rival candidates will see that anything remotely objectionable about a given individual is thoroughly aired. Whether a Presidential Commission could improve on the results or not, it would undoubtedly prolong the process even more than the present system. Similarly, it seems doubtful that such a group could improve significantly on the availability, quality, necessity or speed of caring for the patient.

There is one area, however, in which a Presidential Commission could be of some value: the determination of the President's fitness to serve during or — in particular — after the acute stage of the illness or injury. Speculations on such capability have not been truly tested since the Wilson days (and one wonders if such could happen again). Franklin Roosevelt's death allowed no debate of the Constitutional process, but did anyone doubt that he was in a precarious health situation well before his final election? What if John Kennedy had survived in fact but not in intellect?

This obviously casual and limited survey of the situation fails to examine the many ramifications of the matter, but one thread connects all the features: it is at the moment primarily a political matter. The value of any such commission should lie in the assurance that it would provide a firm, acknowledged and supportable basis in the medical principles present. That would be enough to chew on before letting the politicians into it. — D.E.G.





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PRESIDENT'S MESSAGE

Ethical Problems for Kansas Physicians

MALPRACTICE ISSUES seem to be the topic of most conversations when physicians gather, but ethical issues never fail to surface, even ethical issues concerning malpractice. Many physicians, frustrated by rising malpractice premiums and changes in the laws intended to control those premiums, begin to conjure up ways to fight back. Job actions and strikes are often considered.

Many changes are occurring in medicine, and everyone seems to be involved. Payment systems are being altered by private insurance companies and by the government. Accessibility of physicians to patients is challenged by HMOs, PPOs and Medicaid. Physician fees are scrutinized by Medicare and by Maximum Allowable Payments (MAPs) by private insurers. Physician care of patients is reviewed and criticized by hospital peers and the PRO. It is not an easy task to be a physician now — not that it ever was.

Quality versus cost issues are raised by patients, third-party payors and by business. How do physicians keep their sanity, faced with these ever-changing concepts and problems?

First, we must be conservative and try not to act impulsively. Our code of conduct and guidelines of ethical behavior must be well ingrained to lead us properly. We must never lose our patients' trust. It is up to us to be our patients' advocates and to ensure that when changes come about, they work to enhance the quality of care delivered. We must be critical of our own and our colleagues' care and comply with the evaluations and procedures required for risk management.



We need to do what we do best — take care of patients and hold their trust inviolate. Job action or strike as a gut response to the malpractice crisis will not in any way help our patients, nor gain their support. We need to accept our responsibility, to work within the system to change injustices, and to ensure continued delivery of quality care.

A handwritten signature in dark ink, reading "Donald V. Hutton" followed by a stylized monogram "D.V.H." to the right.

President

Motrin[®] 800 TABLETS mg ibuprofen



Extra strength
Convenience
Economy



A Century
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ANNOUNCING NEW

Keflet[®] TABLETS cephalexin

All the advantages of cephalexin in a convenient tablet form

- Backed by over 15 years of clinical experience
- Smaller tablet is specially shaped and coated for easier swallowing
- May enhance patient compliance, particularly among the elderly
- Tablet dosage form may be appreciated by patients of all ages

NEW Keflet Tablets are available as:



Keflet is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-sensitive patients.

Brief Summary. Consult the package literature for prescribing information. Indications and Usage: Keflet[®] Tablets (cephalexin, Dista) are indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Respiratory tract infections caused by *Streptococcus pneumoniae* and group A β -hemolytic streptococci (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. Keflet is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of Keflet in the subsequent prevention of rheumatic fever are not available at present.)

Otitis media due to *S. pneumoniae*, *Haemophilus influenzae*, staphylococci, streptococci, and *Neisseria catarrhalis*.

Skin and skin structure infections caused by staphylococci and/or streptococci

Bone infections caused by staphylococci and/or *Proteus mirabilis*
Genitourinary tract infections, including acute prostatitis, caused by *Escherichia coli*, *P. mirabilis*, and *Klebsiella* sp.

Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

Contraindication: Keflet is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEPHALEXIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to Keflet.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Precautions: General—Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to Keflet occurs, the drug should be discontinued and the patient treated with the usual agents (eg, epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflet may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Keflet should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

As a result of administration of Keflet, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix[®] tablets but not with Tes-Tape[®] (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—The daily oral administration of cephalexin to rats in doses of 250 or 500 mg/kg prior to and during pregnancy, or to rats and mice during the period of organogenesis only, had no adverse effect on fertility, fetal viability, fetal weight, or litter size. Note that the safety of cephalexin during pregnancy in humans has not been established.

Cephalexin showed no enhanced toxicity in weanling and newborn rats as compared with adult animals. Nevertheless, because the studies in humans cannot rule out the possibility of harm, Keflet should be used during pregnancy only if clearly needed.

Nursing Mothers—The excretion of cephalexin in the milk increased up to 4 hours after a 500-mg dose; the drug reached a maximum level of 4 μ g/mL, then decreased gradually, and had disappeared 8 hours after administration. Caution should be exercised when Keflet is administered to a nursing woman.

Adverse Reactions: Gastrointestinal—Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely. The most frequent side effect has been diarrhea. It was very rarely severe enough to warrant cessation of therapy. Dyspepsia and abdominal pain have also occurred. As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

Hypersensitivity—Allergic reactions in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson Syndrome, or toxic epidermal necrolysis have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported.

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Reversible interstitial nephritis has been reported rarely. Eosinophilia, neutropenia, thrombocytopenia, and slight elevations in SGOT and SGPT have been reported.

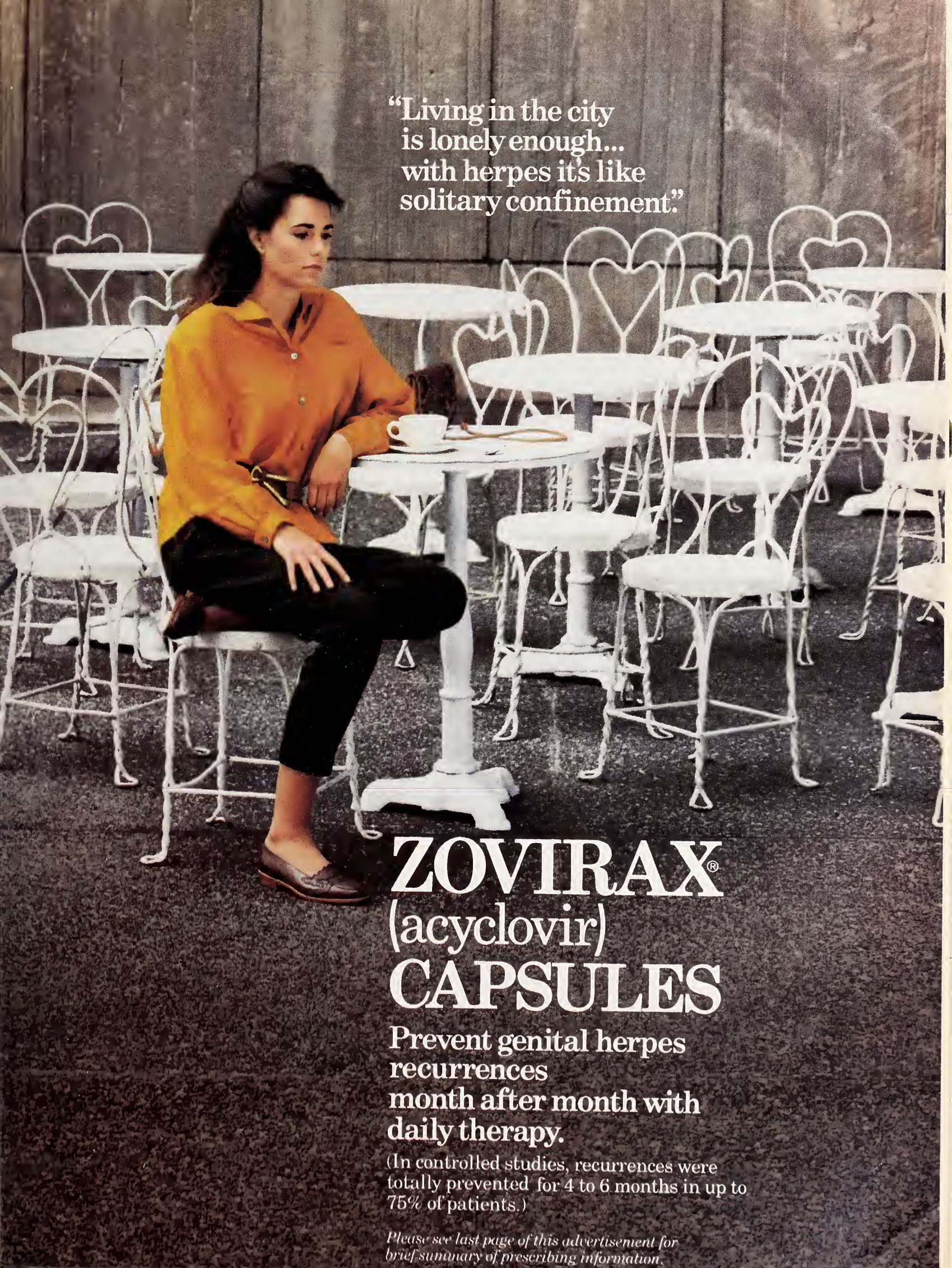
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"Living in the city
is lonely enough...
with herpes it's like
solitary confinement."

ZOVIRAX[®] (acyclovir) CAPSULES

**Prevent genital herpes
recurrences
month after month with
daily therapy.**

(In controlled studies, recurrences were
totally prevented for 4 to 6 months in up to
75% of patients.)

*Please see last page of this advertisement for
brief summary of prescribing information.*

ZOVIRAX[®] (acyclovir) CAPSULES

**Help free your
patients from
recurrences.**

Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks — month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

Generally well tolerated

Daily therapy with ZOVIRAX CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/vomiting, vertigo, and arthralgia.

The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

*Please see brief summary of
prescribing information on next page.*



Prevent recurrences month after month* **ZOVIRAX®** (acyclovir) **CAPSULES**

Brief Summary

INDICATIONS AND USAGE: Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psycho-social difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

First Episodes (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

Recurrent Episodes:

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

CONTRAINDICATIONS: Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

WARNINGS: Zovirax Capsules are intended for oral ingestion only.

PRECAUTIONS: General: Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

Drug Interactions: Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parental doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F₁ generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a

maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days post-dose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS — Short-Term Administration: The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

Long-Term Administration: The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

Chronic suppressive therapy for recurrent disease: One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

Intermittent Therapy: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

Patients With Acute or Chronic Renal Impairment: One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance ≤ 10 ml/min/1.73/m².

HOW SUPPLIED: Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200" - Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.

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SCIENTIFIC ARTICLES

Surfactant Supplementation Trial: Interim Analysis

BARRY T. BLOOM, M.D.,* *Wichita*

Introduction

NEONATAL RESPIRATORY DISTRESS SYNDROME (RDS) is a complex illness characterized by progressive respiratory failure. Abnormal surface tensions have been measured in the tracheal effluents of infants affected by this disease, documenting the biophysical nature of the illness. Surfactants are endogenous products of phospholipids synthesis in the type II pneumocyte which modify the surface tension of the terminal airways and alveoli, allowing for the clearing of alveolar fluid and maintenance of lung volume at end expiration. Deficiency or inhibition of these surface active materials results in pulmonary edema and progressive atelectasis which present clinically as respiratory distress.

Respiratory Distress Syndrome is the most significant respiratory disorder among preterm infants, affecting more than 40,000 infants in the United States per year. The overall mortality remains in excess of 20%, even with the advent of regionalization and improvements in mechanical ventilation.¹ During 1985, 113 infants were born at Wesley Medical Center at less than 31 weeks' gestation. This gestational age group is at high risk (83%) for complications of RDS, including death or chronic pulmonary disease. Although the improvements in neonatal conventional mechanical ventilation have reduced the mortality to 33%, there remains a 50% incidence of chronic pulmonary disease in the survivors. Chronic pulmonary disease, frequently referred to as bronchopulmonary dysplasia, places an enormous burden on the cost of providing neonatal

intensive care, the Pediatric Intensive Care facility, the parents of these infants and society in general.

Early attempts to supplement the neonate's inadequate endogenous surfactants included studies by Robillard and Alarie (1964), Shannon and Bunnell (1976) and Ivey *et al.* (1977). Equivocal results from these studies were related to problems of dosage, delivery techniques, "incomplete" surfactants, and the lack of advanced neonatal ventilatory techniques.

In 1980 Fujiwara treated 10 infants with a single intratracheal dose of a lipid extract of beef lung homogenate, noting a dramatic reduction in the FiO_2 required to maintain a $\text{PaO}_2 > 50$ torr.² Recently these workers have further described the effect of this surfactant in 20 infants.

Morley *et al.* used a single dose of 25mg/kg of a synthetic preparation of DPPC and PG from egg lecithin (7:3) prepared as a powder and blown into the airways at birth.³ A variety of study designs have failed to demonstrate efficacy of this material. Morley recently presented data from a multicentered trial of DPPC/PG vortexed in saline (7:3), demonstrating an improvement in oxygenation approximately 12 hours after surfactant administration.⁴

Enhoring and co-workers in Toronto, Canada, and investigators in Buffalo and Rochester, New York, have conducted randomized trials of (Infasurf) bovine surfactant.⁵⁻⁷ Their results document the beneficial effects of bovine surfactant in reducing selected ventilatory support measures, the incidence of pulmonary morbidity, and the number of days of oxygen therapy.

Hallman *et al.* reported the technique for isolating human surfactant from term amniotic fluid obtained from uncomplicated pregnancies at cesarean section.⁸ Subsequently they reported a randomized controlled "rescue" trial.⁹ Treated infants had a significantly better survival rate and less bronchopulmonary dysplasia than controls. More recently we have defined the benefit in ventilatory parameters and the lessening of mortality and selected

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The obstetrical physicians and the neonatologists at Wesley Medical Center deserve recognition for their participation in and support of this project.

Approval for the surfactant trial was obtained on June 24, 1986. Initial funding was provided by Wesley Foundation and Wesley Medical Research Institutes. Additional funding was obtained from the March of Dimes and Children's Miracle Network Telethon and a seed grant from UKSM-W.

morbidities in infants receiving human surfactant in a randomized controlled "prophylactic" study.¹⁰

This interim report is mandated by our project design so that we may determine if the new treatment is accompanied by any untoward effects.

Materials and Methods

Surfactants, drug administration and patient man-

agement. Human surfactant was provided by collection of amniotic fluid at Wesley Medical Center. Extraction by the method of Hallman *et al.* was performed in the surfactant laboratory at the University of California, San Diego. Bovine Lung Lavage Surfactant (Infasurf) was provided by Edmond Egan of ONY Inc., Buffalo, New York, in cooperation with Dr. William Topper at KUMC, Kansas

TABLE 1

	<i>Treated</i>	<i>Control</i>	<i>p Value</i>	<i>Interp</i>
Total	18	20		
<i>Prenatal</i>				
PIH	2	4	0.76	NS
Chronic Hypertension	1	1	0.52	NS
Maternal Diabetes	0	1	0.96	NS
Suspected Chorioamnionitis	4	4	0.82	NS
Beta Agonists Tocolysis (hours)	59 ± 143	30 ± 107	0.48	NS
<24 hours	2	6		
24-48 hours	1	1		
>48 hours	4	2	0.46	NS
Steroids (hours)	0	1.1 ± 4.9	0.35	NS
>24 Hours	0	1	0.96	NS
Vaginal/C-Section	14	17	0.88	NS
Vertex/Breech/Other	13/5/0	13/5/2	0.39	NS
Labor	13	13	0.88	NS
Antepartum Bleeding (Acute/Chronic)	7/1	3/2	0.24	NS
<i>Neonatal</i>				
Birthweight (grams)	1148 ± 265	968 ± 254	0.04	
Gestational Age (weeks)	28.2 ± 1.8	28.0 ± 2.2	0.76	NS
Male/Female	10/8	12/8	0.96	NS
Small for Dates	1	3	0.68	NS
Fetal Distress	11	7	0.20	NS
Intrauterine Asphyxia	1	1	0.52	NS
5 min Apgar <5	3	3	0.76	NS
Race (Cauc/Black/Other)	14/3/1	16/4/0	0.56	NS
<i>Outcome</i>				
Death	2 (11.1%)	6 (30%)	0.3	NS
RDS related	0	5	0.07	
Other cause	2	1		
	Herpes/Candida	Peritonitis		
Bronchopulmonary Dysplasia	3 (16.7%)	11 (55%)	0.03	
Pulmonary Interstitial Emphysema	3	12	0.02	
Pneumothorax	1	8	0.03	
Patent Ductus (requiring intervention)	7	14	0.11	
Necrotizing Enterocolitis	1	4	0.40	NS
Retinopathy of Prematurity	8	7	0.57	NS
Intraventricular Hemorrhage (all)	2	7	0.22	NS
Grade I & II	1	4		
Grade III & IV	1	3		
Duration of IMV (days)	9.1 ± 11.3	27.4 ± 34.7	0.04	
Duration of FiO ₂ >0.3 (days)	3.6 ± 5.4	22.8 ± 29.2	0.009	
Duration of supplemental O ₂ (days)	11.2 ± 16.4	47.5 ± 53.7	0.009	
Duration of CPAP (days)	9.4 ± 12.6	11.7 ± 12.7	0.59	NS
Apnea of Prematurity	16	16	0.76	NS

City. Immediately after delivery, the infants were intubated with an endotracheal tube through which a single dose of 90–105 mg of surfactant was instilled. Positive pressure ventilation was begun after the instillation.

Clinical management guidelines were limited only by acceptable blood gas ranges (PaO₂ 45–60 torr and PaCO₂ 45–60 torr). Arterial blood gases were obtained every four hours for 96 hours, and chest radiographs were obtained daily for five days. After immediate stabilization, the infants' ventilator changes, patent ductus intervention, use of nasal CPAP for apnea and the decision for extubation were made by the house staff in consultation with the attending neonatologist.

Patient population. Infants born in Wesley Medical Center prior to the 33rd week of gestation were candidates for enrollment. Parenteral informed consent was obtained prior to delivery when surfactant was available. Treatment with either human or bovine surfactant was determined by availability. Infants who had malformations which affect lung development or prolonged oligohydramnios, or infants who were felt by the attending neonatologist not to require intubation in the delivery room, were excluded.

Results

Twenty control infants, 6 human surfactant (HS) infants and 12 Infasurf (IS) infants have met the criteria for interim analysis (less than 31 weeks' gestation and at least 2 months post delivery). Definition of the beneficial effects of surfactant administration in infants beyond thirty-one weeks' gestation will require a larger patient population because of the lower incidence of RDS and its complication in this group. Interim analysis is not intended to test our hypothesis, but to reassure our Investigational Review Board that no untoward effects are noted with this new drug; therefore, this analysis will be helpful in justifying continuation of this trial. In fact, the greater than 50% reduction in death rate is not statistically significant because of the small numbers in both groups. Values are listed as the mean and standard deviation of the mean. Chi square with continuity correction and two tailed unpaired T-tests were used where appropriate. (See Table 1.)

Discussion

One hydropic infant and one infant with severe prolonged oligohydramnios have been treated as well.

The non-RDS deaths were related to congenital Herpes Simplex infection and Candida sepsis in the first week after delivery.

The decrease in RDS-related mortality and chronic lung disease is similar to that which was expected. One statistical concern is that treated infants at this point in the trial have a greater mean birthweight. The impact of this variance on the pulmonary outcome cannot be defined until further analysis is undertaken (three of the controls were small for gestational-age infants, accounting for some of the variance, yet this would predict for those SGA infants a better pulmonary outcome). If these results are supported during the remainder of the study, they infer a dramatic improvement in the outcome of very preterm infants in our community. Direct comparison analysis of IS and HS to determine if there is a statistically significant difference in the efficacy of either preparation will be done when enough infants have been treated with HS to provide a reasonable base. Continuation of this trial is justified by these results.

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KANSAS MEDICAL SOCIETY

Newsletter

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NOVEMBER 1987

MALPRACTICE UPDATE

As reported in the last issue of the newsletter, the professional liability problem continues to intensify on the heels of the Kansas Supreme Court's recent ruling invalidating one part of the medical malpractice tort reform package. In July, the Court rejected the new law changing the "collateral source rule" in medical malpractice lawsuits.

As a result of the Court's ruling, total premiums for physicians are expected to increase by as much as 70% by next July 1. The surcharge premium every physician pays into the Health Care Stabilization Fund is expected to go from the current 90% to as much as 150%, a 67% increase. Additionally, Medical Protective, which insures about 40% of the state's physicians, has just filed for an 84% rate increase, to be effective in January. That request, however, is being carefully studied by the Insurance Commissioner, and it is not yet certain how much will be granted.

Although the other insurers in the state, notably St. Paul and Medical Defense, have not yet indicated what their plans are for a 1988 rate increase, we fully expect both of those companies to request premium increases before July 1988.

While the Supreme Court has not yet ruled on the other aspects of the tort reform package, such as the caps on awards, it is anticipated that those items will also be rejected by the Court in the near future. Consequently, KMS and the Kansas Hospital Association are developing legislative proposals to correct the constitutional problems in the key elements of the tort reform package, so that they can be implemented by the 1988 Legislature. Other legislative proposals are being carefully studied, such as a "phasing-out" of the Health Care Stabilization Fund and the mandatory insurance requirement. These changes, along with the tort reforms mentioned above, will have a significant impact on premiums, and could significantly mitigate the increases expected in 1988.

KMS encourages you to watch your mail for special communications on the malpractice problem. Every physician in the state, KMS member or not, will receive regular updates on our legislative plans, our educational efforts, and developments in the insurance area, such as premium costs. It is essential that every KMS member be well informed on this subject, so you're encouraged to review the information sent to you. If you have any questions on any of that information, please contact the KMS office at 1-800-332-0156.

In This Issue...

- Malpractice update
- Reporting burn wounds
- Physician assistant regulations postponed
- CPT-88
- AIDS
- No 'typical physician'
- Shame and humiliation in medical encounters
- Malnutrition among hospitalized patients
- Topeka law firms merge
- Alzheimer's disease

REPORTING BURN WOUNDS

By now most physicians have probably received a letter from the State Fire Marshal containing the information that an elaborate report must be completed every time a second- or third-degree burn wound is treated. The letter states that the "legislature recently passed a new law, and regulations implementing this law are now in place."

Actually, the 1985 Legislature amended an old law which requires the Fire Marshal to adopt administrative regulations that outline procedures for reporting fires and explosions and for investigating those incidents. The 1985 amendment adds wording to include reporting and investigation of second- and third-degree burn wounds caused by fire, explosion, heat or chemical substances.

The regulation adopted by the Fire Marshal requires that reports of burn wounds be submitted on forms provided by the Fire Marshal and that the reports must be mailed no later than the Monday following the date of first treatment. There is a certain irony in that it took the Fire Marshal ten months to adopt a regulation implementing a change in the law, and over a year to distribute the forms.

The Kansas Medical Society has heard from a number of members who feel that this new bureaucratic exercise is cumbersome and, in many instances, probably unnecessary. The Kansas Hospital Association has been hearing similar complaints.

In a recent letter to the State Fire Marshal, KMS staff has expressed a desire to pursue modification of the regulation to require reporting only when investigation by public safety officials is warranted. The letter says that the Society would prefer to exhaust any possible administrative remedies before asking the Legislature to amend the law.

PHYSICIAN ASSISTANT REGULATIONS POSTPONED

One item on the Board of Healing Arts' agenda for October 10 was a discussion of proposed regulations governing activities of physicians' assistants. This was not intended to be a public hearing. The Board's General Counsel simply wanted permission to publish the proposed regulations and schedule a formal hearing at a later date.

The Board discussion began to resemble a public forum when a representative of an association of physicians' assistants was recognized for comments. His primary complaint was that the drafted regulations did not coincide with his impressions of details agreed to by an ad hoc committee. Principal concerns seemed to be focused on location restrictions and limitations on authority to prescribe drugs.

It became apparent that certain Board members did not want to conduct an unscheduled public hearing at that time. On the other hand, one member expressed a desire to hear the entire list of concerns brought by the PAs' representative. By a close vote, a motion was adopted to curtail the discussion and send the regulations back to committee.

As a result of the Board action, the proposed regulations will have to be re-drafted and once again sent to the Attorney General and the Department of Administration for review. Then a genuine public hearing must be scheduled in order for the Board to adopt some version of the regulations governing physicians' assistants.

CPT-88

The 1988 volume of AMA's CPT will be available in December. Those ordering CPT-88 also will be given their choice of one of eight companion Minibook listing codes for procedures performed in specialty fields. Prompt ordering is suggested, since four to six weeks should be allowed for delivery. Order forms may be obtained from American Medical News or AMA specialty journals where promotional notices will be appearing regularly.

AIDS

California has enacted a law which relieves physicians of criminal or civil liability for disclosure of a spouse of a partner whose test results indicate HIV seropositivity. The statute is permissive and does not impose a requirement of disclosure upon the attending physician. Another California statute permits any person who is tested for the presence of the HIV antibody to disclose the identity of sexual partners or persons with whom he has shared the use of hypodermic needles to the county health officer, who in turn may alert the third party about exposure without disclosing any identifying information about the individual making the disclosure.

Illinois has empowered the state Department of Health to adopt rules authorizing interviews of all persons infected with AIDS and the HIV virus in order to investigate the source of the disease. Persons contacted under the law who reveal the names of sexual contacts during the course of the investigation will not be held civilly liable for such revelation unless the revelation is made falsely or with reckless disregard for the truth.

NO 'TYPICAL PHYSICIAN'

In the past 30 years, the identity of the average physician has been fragmented due to increased specialization, practice situations and employment circumstances. Medical societies can no longer aim their message at the "average practicing physician." He does not exist. Rather, a series of messages aimed at specific subpopulations must be delivered.

SHAME AND HUMILIATION IN MEDICAL ENCOUNTERS

Patients are at high risk for experiencing shame and humiliation in any medical encounter, yet this important aspect of interaction between patient and health professional is often neglected, a recent report in Archives of Internal Medicine suggests. Shame and humiliation enter as factors because patients often perceive diseases as defects, inadequacies or shortcomings, writes Aaron Lazare, M.D., of the University of Massachusetts Medical Center, Worcester. Furthermore, a visit to the hospital or doctor's office requires physical and psychological exposure.

"Patients respond to the suffering of shame and humiliation by avoiding the physician, withholding information, complaining and suing," Lazare says. "Physicians may also experience shame and humiliation in medical encounters, resulting in their counterhumiliation of patients and dissatisfaction with medical practice." A heightened awareness of these issues can help physicians lessen the severity of the problem in both patients and themselves, says Lazare.

As this report suggests, there is no substitute for good personal interaction with patients. Human and psychological aspects of any medical treatment play a major role in the success or failure of that treatment. The very human interchange between physician and patient may be the key to success.

MALNUTRITION AMONG HOSPITALIZED PATIENTS

Although studies have shown that 25 to 50 percent of patients admitted for acute hospital care are malnourished--a problem that can affect their recovery--doctors are not being taught to recognize this problem, concludes a report in a recent issue of Archives of Internal Medicine. Ronenn Roubenoff, M.D., of the Johns Hopkins Hospital, Baltimore, and colleagues, studied all patients admitted to an acute medical service before and after their doctors were taught to recognize nutritional deficiency early and intervene appropriately. During the first phase of the study, the house staff correctly identified only two of 16 malnourished patients. But after training, 14 patients at nutritional risk all were identified correctly, using a simple screening device requiring only routine admission data. "We suggest that physician education is a cost-effective and sensible approach to this problem," the authors conclude.

TOPEKA LAW FIRMS MERGE

The Topeka law firm of Goodell, Stratton, Edmonds and Palmer has merged with another local law firm, Colmery, McClure, Letourneau, Merriam and Stauffer, P.A. The consolidated firm will practice law under the name of Goodell, Stratton, Edmonds and Palmer. Combined, the new firm has strong experience in litigation, health care law, real estate, labor law, securities, taxation, estate planning, commercial law, bankruptcy and media law. Attorney Wayne Stratton is the KMS legal counsel.

ALZHEIMER'S DISEASE

Kansas Governor Mike Hayden, in a ceremony on November 10, signed the proclamation designating November as Alzheimer's Disease Month in Kansas. President Reagan had previously endorsed the month at the national level. Resource packets containing information on the disease and a list of support groups within the state are available through the HELPLINE, 1-800-432-3535 (Topeka: 296-4986), or by writing to the Kansas Department on Aging, 610 West 10th, Topeka, 66612. There is no charge for the information. At the national level, the most complete source of information is the Alzheimer's Disease and Related Disorders Association, Inc. (ADDA), 70 East Lake Street, Chicago, IL 60601; phone: 1-800-621-0379.

Idiopathic Thrombocytopenic Purpura in Children: New Therapeutic Considerations

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CHILDHOOD ITP is an acquired bleeding disorder characterized by sudden onset of purpura, severe peripheral thrombopenia and normal to increased megakaryocytes in the bone marrow. It usually occurs following a viral illness and has an excellent prognosis in children under 10 years of age.

Etiology and Pathogenesis

The syndrome of viral-induced thrombocytopenia is well known, but the exact nature of events terminating in acute childhood ITP is not clear. The alteration of the platelet membrane by circulating antigen-antibody complexes is thought to result in massive platelet sequestration in the reticulo-endothelial system, with the spleen being the principal organ of destruction. Most investigators favor an immunologic mechanism in the pathogenesis of childhood ITP, but evidence for a specific antiplatelet antibody is lacking. However, Dixon and Ross in 1975 documented the presence of a platelet-associated IgG (PAIgG) in adults, which was later recognized in children as well. The PAIgG is elevated in the majority of patients and correlates with the degree of thrombopenia.

Natural history. Most affected children are 2–5 years old, with the peak occurrence in the fall and winter. Both sexes are affected equally, except in adolescents, where females predominate. The incidence seems to be higher in whites, but this could be due to the difficulty in diagnosis of mild purpuric lesions in dark-skinned children.

The course in children under 10 years of age is usually benign. Approximately 80–90% of patients recover within 6 months, with an average duration of thrombopenia of 3 weeks. Most patients who remain thrombopenic beyond 6 months have chronic or recurrent ITP.

In severely thrombocytopenic patients, the risk of bleeding is high during the early days of onset

and may involve many organs. Intracranial hemorrhage is the most serious, but rare, complication and occurs in less than 1% of patients. Gastrointestinal, genito-urinary and pulmonary bleeding may also cause considerable morbidity in some patients.

Laboratory Evaluation

Thrombocytopenia in an otherwise normal peripheral blood count and morphology in conjunction with the history of a viral illness suggests ITP. The examination of a bone marrow aspirate is recommended by many hematologists, including us, to rule out aplastic or malignant disorders and should be done if a therapeutic modality such as steroid treatment is contemplated, or if close follow-up is not feasible. There is no reliable test to identify patients with true immune-mediated variety for further evaluation and management. The quantitation of platelet-bound immunoglobulins is a major step toward identification of high-risk patients. A rapid and simple flow cytometric technique is available at the University of Kansas Medical Center for quantitation of platelet surface-bound antibodies. Anti-human immunoglobulins and complement are used to detect the antibodies in this highly specific and sensitive method. This test can help in predicting the response to steroid or intravenous IgG treatment, and may aid in identifying patients with a chronic outcome. Its use is strongly recommended prior to initiation of any treatment. Other tests may include Epstein-Barr virus serology; assays for serum immunoglobulins G, A, and M; Coombs' test and antinuclear antibody to rule out collagen vascular disease; associated autoimmune hemolytic anemia (Evans syndrome) and IgA deficiency.

Management of Acute ITP

The goal of any form of management should be the prevention of serious bleeding complications. This usually can be achieved by restriction of activities and avoidance of medications that alter the platelet function (i.e., aspirin, antihistamines, etc.).

The use or non-use of steroids in the management of ITP in children is still controversial. In a large group of patients managed conservatively without

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the use of steroids, Lusher, et al. reported a recovery rate of 80–90% and no serious hemorrhages in 465 children. On the other hand, recent controlled studies indicate that steroid therapy can shorten the duration of thrombopenia. This is important because it allows the speedy return of the youngster to normal activities. It is also important to note that there is no evidence to prove steroid therapy reduces the risk of ICH.

Prednisone is commonly given in a dose of 2 mg/kg/day in divided doses for 2–3 weeks. The response is variable, but will generally take several days for a significant rise to occur. Occasionally, following a successful course of steroid treatment, a sudden drop in the platelet count is seen when the steroid is stopped. This should not necessarily be seen as an indication to restart the drug, since the cycle is likely to repeat itself. Most of these patients recover shortly after the relapse.

Recently, high-dose intravenous gammaglobulin (IV IgG) has been used in some patients with acute ITP. The recommended dose is 1 gm/kg given as a single, daily infusion for 1–3 days, depending on response. It produces results similar to those of prednisone in rapidly responding acute ITP, whereas IV IgG seems to do better in slow responders. The cost of IV IgG treatment precludes its routine use in childhood ITP where recovery is expected in most instances. Side effects of IV IgG are limited mostly to allergic reactions, and a careful process of production has eliminated the possibility of contamination with the human immunodeficiency virus. But, non A- non B-hepatitis has been reported in a few patients. At this juncture we need more studies to convince us that IV IgG is more effective and safer than conservative management or prednisone treatment of childhood ITP before embarking on its use in all patients.

Chronic ITP

For 10–20% of patients who do not recover by the arbitrary limit of 6 months, the treatment will depend on the severity of the thrombopenia and related complications. Those who maintain platelet counts in excess of 50,000 and — more importantly — do not exhibit frequent hemorrhagic manifestations may not need any treatment. Splenectomy has for a long time been considered the treatment of choice for those who continue to have severe thrombocytopenia. A homologous platelet survival test should be considered prior to splenectomy if non-ITP causes such as a hereditary thrombocytopenia cannot be ruled out. The splenectomy, however, fails to improve thrombopenia in 10–15% of patients and is

followed by an increased susceptibility to bacterial infections. The treatment with IV IgG has provided an effective alternative in this group of patients with chronic ITP. It can buy time for patients who have an excellent chance of recovery but continue to be thrombopenic, or postpone splenectomy in younger patients. Whether it can in fact cure chronic ITP remains to be proven. The recommended dose in chronic ITP is 2 g/kg as induction treatment, usually given over 5 days. A platelet rise is frequently observed after 48–72 hours of therapy in responders and may surpass the 150,000–200,000 mark by the end of treatment. The platelet count, however, declines with the half-life of IgG. A booster treatment (0.4–1.0 g/kg) is usually given at platelet counts of less than 40,000 and repeated as needed. Those who respond may show a gradual prolongation of recovery with adequate counts lasting up to 10–12 weeks. The mechanisms of action of IV IgG are postulated to be the blockage of the Fc receptors of the monocyte-macrophage system and/or elimination of the circulating antigen-antibody complexes.

Splenectomy can be reserved for patients who are resistant to IV IgG, or who develop severe allergic reactions to the product. When preparing for splenectomy, a short course of prednisone or IV IgG therapy prior to the procedure will, in most cases, increase the platelet count to a safe level for the operation. The platelet count rises immediately following the ligation of the splenic pedicle, and further therapy is not needed.

Patients with chronic ITP should be investigated for the presence of an underlying illness such as systemic lupus erythematosus. Female patients of any age who develop chronic ITP should become aware of the possibility of pregnancy-related problems, even if the thrombopenia is resolved. Fetal hemorrhage and losses can occur, due to severe thrombopenia as a result of transplacental passage of antibodies. Steroid treatment or IV IgG with or without C-section have been applied successfully in this condition.

Acute Management of Life-Threatening Bleeding

Intracranial, pulmonary, gastrointestinal and genito-urinary hemorrhages are the most serious complications of ITP. Any symptom such as headache, neurological signs, altered consciousness, seizure, etc. should immediately be investigated and therapeutic measures undertaken. The patient should be started on high-dose IV IgG and/or steroids, and appropriate studies, such as CT of the head, taken. If an intracranial hemorrhage is documented (or other

uncontrolled hemorrhages occur), an emergency splenectomy is indicated. Immediately following the splenectomy, and under the same anesthesia, craniotomy or other explorations are performed to correct the underlying pathology.

Summary

Childhood ITP is a benign syndrome with spontaneous recovery expected in most patients. Steroid treatment is probably indicated in severe patients, since it may reduce the duration of thrombopenia. Platelet increments obtained with the use of IV IgG in acute ITP may be similar to the results of steroid therapy, but more costly, while it is an efficient means of management in patients with chronic ITP. Any indication of ICH should be managed vigorously with IV IgG, IV steroids and emergency splenectomy.

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MEDICINA ET LEX

Birth Defect Suits: The Cost

WAYNE T. STRATTON, J.D.,* *Topeka*

MANY PHYSICIANS are aware of the sharp increase in premiums if one's practice includes obstetrics. Some may not be aware of the number or the amount of claims experienced by Kansas physicians and hospitals. Some insurers are becoming more restrictive in their underwriting, and physicians are increasingly eliminating obstetrics from their practice.

The number and severity of such suits continues to threaten the availability of health care in Kansas. Because of the importance and timeliness of this problem, three "Medicina et Lex" columns will discuss the costs of such claims, the importance of recent research and writings upon the subject, and suggestions for the avoidance of such suits.

Since 1976, the Kansas Insurance Department has maintained records of closed claims of companies writing malpractice insurance within the state and has annually accounted for the payments from the Health Care Stabilization Fund. These data reveal that 28% of the claims are incurred by class VIII physicians, which includes obstetrics and gynecology. Of all claims against all providers, 10% are birth-related; however, these claims account for 21.4% of the total sums paid by the companies.

The Fund's expense, which relates to payments above the basic limits of insurance, is more disconcerting. Birth-related cases account for 15% of all cases filed but represent 35% of all monies paid from the Fund.

While the total amount incurred is unknown — since there are numerous cases in litigation, and some in which the Fund is obligated for future payments — the amount paid for such claims to date is approximately \$20 million, with a median of



Mr. Stratton's discussion topics are selected for their medicolegal interest to physicians. Readers are invited to submit questions or items of interest in this area for attention in this series.

\$550,000. The average amount paid in such cases is approximately three times the payment in other types of cases.

The scope and extent of the problem are clear. It has been estimated that a child is born once an hour with cerebral palsy and once every 15 minutes with mental retardation. Many others have defects of a different type. All that is required for such cases to reach a jury is for someone to testify that "a standard" was violated, and that this caused the child's condition. All too often the causation is supplied by the pediatrician whose diagnosis, sometimes superficially determined, is "perinatal asphyxia."

Cases of this type are notoriously difficult to defend. Many people, including jurors, expect a healthy baby from each pregnancy. The plaintiffs' attorneys are able to project millions of dollars in future damages, as they always assert the child is expected to live a normal life span. In many instances, physicians from faraway places testify about departures

*KMS Legal Counsel.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE, or the Kansas Medical Society. For further information, contact Mr. Stratton, 215 E. 8th, Topeka KS 66603, 1-800-332-0248.

from standards, and some do so in hundreds of cases. In every case, the heartstrings of the jury are pulled by the presence of the retarded or palsied infant.

The conclusion is obvious: If claims, and therefore premiums, are to be controlled and the Fund's expenses reduced, something must be done to bring down the costs of obstetric malpractice cases. The recent Kansas legislation was designed to deal with cases such as this. Among other things, it:

- a. limited damages to a sum sufficient to care for the child;
 - b. provided for the payment of any judgment on a periodic basis by the purchase of an annuity;
 - c. allowed evidence that collateral sources were, in actuality, paying for much of the damages.
- The Kansas Supreme Court has now struck down as unconstitutional the modification of the collateral source rule, using broad language that leaves many of the other statutes in doubt.

While legislation may yet assist in dealing with the crisis, physicians need to be aware of the significance of recent research and the ways in which the exposure can be reduced. Recent research and the writings of nationally recognized experts will be summarized in next month's column. The third article will discuss ways which have been suggested to avoid such cases.

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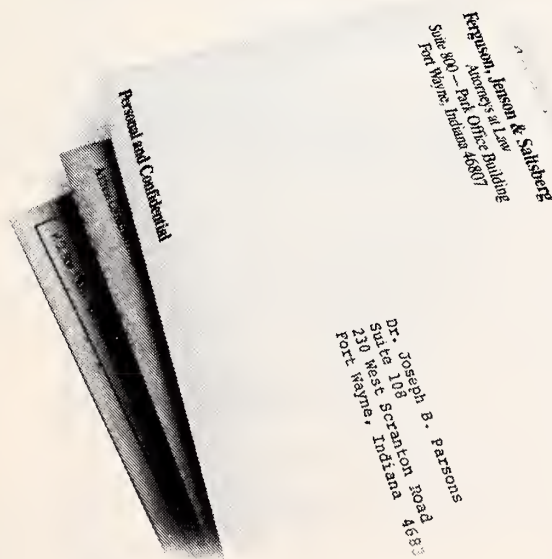
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To Help a Sick Friend

CALL 1-800-332-0156. Ask for Laurie or Val.

This is all you need to do to assist a colleague who may be impaired. Many of us are reluctant to make such a call out of "loyalty" to a colleague or a sense of "betraying a confidence." But failure to assist a possibly impaired colleague is no service to him or her. A better way to look at it is that you are helping a sick friend, just as if he had cancer, a fracture or a stroke. These are the reasons for assisting an impaired colleague:

1. Prevention of possible harm to the public.
2. Continuation of a physician's service to the public.
3. Protection of a physician's career, family, health and even life.
4. Protection of the reputation of the profession.
5. Your legal duty.

Kansas House Bill 2661, passed in 1986, provides duties, penalties and protections for the health care provider in reporting an impaired physician. Under the law, you as a physician (health care provider) have a legal duty to report any other health care provider about whom you have personal knowledge of impairment. Failure to do so is a Class C misdemeanor and also may result in suspension, revocation or limitation of your license. Your protection is:

1. Immunity from liability, except for known false reports.
2. Confidentiality of reports, records and deliberations of committees and individuals.
3. Required testimony only in disciplinary hearings.

Your impaired colleague also has protection and can be denied medical staff privileges according to the law ONLY for impairment, NOT for treatment of impairment.

The definition of impairment in HB 2661 is "... inability to practice the provider's profession with reasonable skill or safety due to physical or mental disabilities, including:

deterioration through the aging process,
loss of motor skill,
abuse of drugs or alcohol. . . ."

Although the above definition does include other causes of impairment besides use/abuse of drugs/alcohol, it is the most common form of impairment and will be the subject of the following discussion.

HR 2661 enabled the Kansas Board of Healing

Arts to enter into an agreement with the Kansas Medical Society to deal with physician impairment. Such a contract was signed and is in effect as of July 1, 1987. This agreement provides:

1. Service to ALL Kansas physicians, M.D. or D.O., member or non-member of the KMS.
2. Anonymity for the impaired physician unless treatment is refused, dropped, or failed, or there is immediate danger to the physician or the public.

The agreement also provides on an operational level for payment of KMS from state funds and for the employment of salaried staff for the KMS Impaired Physicians Program. KMS is required to make periodic reports to the Kansas Board of Healing Arts.

The Kansas Medical Society Impaired Physicians Committee works as follows:

1. A report is made to KMS IPC.
2. An investigation is made by KMS IPC.
3. If indicated, treatment is recommended, monitored and followed by KMS IPC.

The report of physician impairment can be made directly to the KMS IPC and should be made by someone who has personal knowledge. A report to the KMS IPC meets the requirements of the law for hospital staffs and their committees. The report of possible impairment is accepted from any source, including the public. Consequently, when a patient or a member of the general public calls the hospital staff office, the local medical society or a physician's office and wishes to report an impaired physician, that person may be instructed to call the KMS IPC directly at the toll-free number. KMS Councilors also serve as members of KMS IPC.

I am the Councilor for the Third District (Johnson County) and am available for advice and assistance in respect to a possibly impaired local physician.

Assisting an impaired physician serves the public, the physician, and the profession. It's an all-win, no-lose situation.

*Eugene W. J. Pearce, M.D.
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The New Tax Law: Hidden Effects on Life Insurance Policies

KEVIN W. WRIGHT, J.D.

THE TAX REFORM ACT of 1986 will affect every taxpayer in the United States. Tax-bracket changes, loss of the appeal of tax-sheltered investments and phase-out of interest deductions will have the largest effects on taxpayers' spending habits and also will make it necessary for taxpayers to rethink their tax strategy.

Hidden in the phase-out of interest deductions is the impact these changes have on financial/life insurance plans. Many professionals have purchased life insurance policies in which the premiums are paid through borrowing. The interest paid for such loans could be deductible, and in the previously high tax brackets, that could result in low net costs.

With the elimination of this deduction, future costs

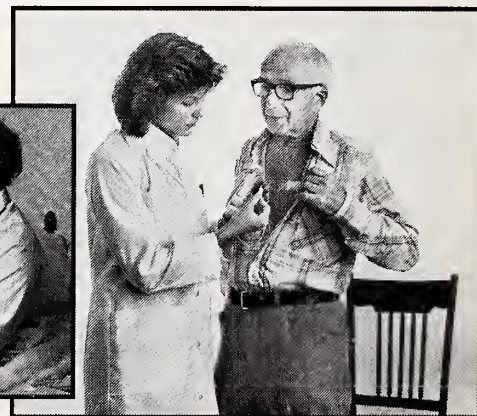
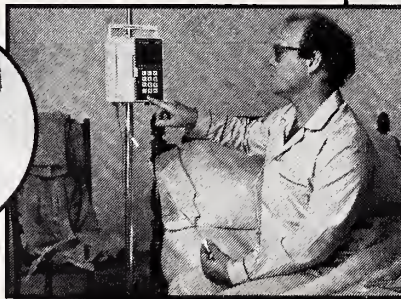
of maintaining these types of policies will become prohibitive. Failure to maintain the policy can cause serious taxable events to occur.

A few insurance companies have instituted programs to "rescue" professionals from these tax traps and rising costs. One new program allows taxpayers to exchange an old policy for a new interest-sensitive universal life policy on a tax-free basis. Once the exchange is complete, the loan can be reduced or even eliminated by making loan repayments with non-taxable withdrawals from policy cash flow. Future premiums can be scheduled to "vanish" without additional borrowing. For more information, contact your insurance agent, or call or write the KMS office.



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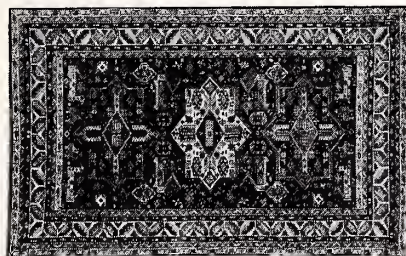
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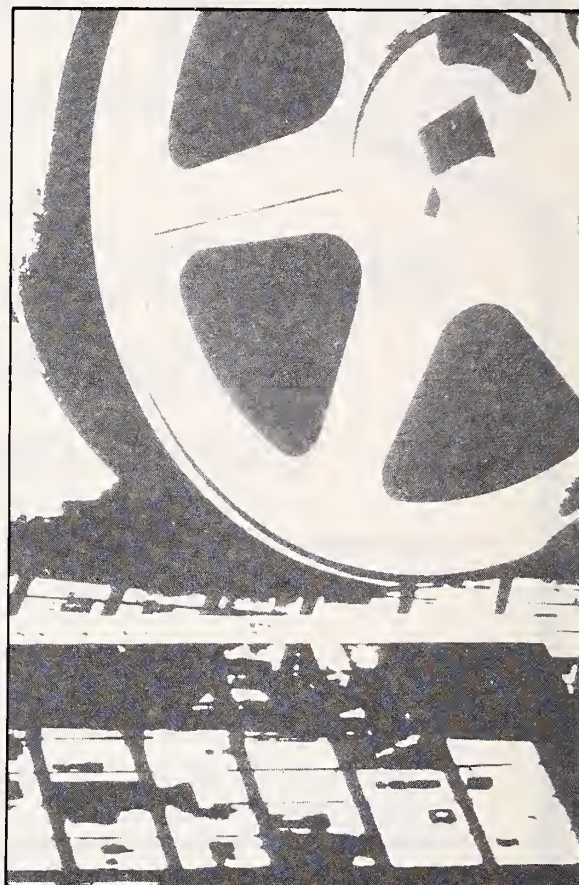
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CONTRAINDICATIONS: Anuria. Hypersensitivity and in patients in hepatic coma or in states of severe electrolyte depletion. Although Bumex can be used to induce diuresis in renal insufficiency, any marked increase in blood urea nitrogen or creatinine, or the development of oliguria during therapy of patients with progressive renal disease, is an indication for discontinuation of treatment.

WARNINGS: Dose should be adjusted to patient's needs. Excessive doses or too frequent administration can lead to profound water loss, electrolyte depletion, dehydration, reduction in blood volume and circulatory collapse with the possibility of vascular thrombosis and embolism, particularly in elderly patients.

Prevention of hypokalemia requires particular attention in patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis and ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, certain diarrheal states, or other states where hypokalemia is thought to represent particular added risk to the patients.

In patients with hepatic cirrhosis and ascites, sudden alterations of electrolyte balance may precipitate hepatic encephalopathy and coma. Treatment in such patients is best initiated in the hospital with small doses and careful monitoring of the patient's clinical status and electrolyte balance. Supplemental potassium and/or spironolactone may prevent hypokalemia and metabolic alkalosis in these patients. In cats, dogs and guinea pigs, Bumex has been shown to produce ototoxicity. Since Bumex is about 40 to 60 times as potent as furosemide, it is anticipated that blood levels necessary to produce ototoxicity will rarely be achieved. The potential for ototoxicity increases with intravenous therapy, especially at high doses.

Patients allergic to sulfonamides may show hypersensitivity to Bumex.

PRECAUTIONS: Measure serum potassium periodically and add potassium supplements or potassium-sparing diuretics, if necessary. Periodic determinations of other electrolytes are advised in patients treated with high doses or for prolonged periods, particularly in those on low salt diets.

Hyperuricemia may occur. Reversible elevations of the BUN and creatinine may occur, especially with dehydration and in patients with renal insufficiency. Bumex may increase urinary calcium excretion. Possibility of effect on glucose metabolism exists. Periodic determinations of blood sugar should be done, particularly in patients with diabetes or suspected latent diabetes.

Patients should be observed regularly for possible occurrence of blood dyscrasias, liver damage or idiosyncratic reactions.

Especially in presence of impaired renal function, use of parenterally administered Bumex should be avoided in patients to whom aminoglycoside antibiotics are also being given, except in life-threatening conditions.

Drugs with nephrotoxic potential and bumetanide should not be administered simultaneously. Since lithium reduces renal clearance and adds a high risk of lithium toxicity, it should not be given with diuretics.

Probenecid should not be administered concurrently with Bumex.

Concurrent therapy with indomethacin not recommended.

Bumex may potentiate the effects of antihypertensive drugs, necessitating reduction in dosage.

Interaction studies in humans have shown no effect on digoxin blood levels.

Interaction studies in humans have shown Bumex to have no effect on warfarin metabolism or on plasma prothrombin activity.

Pregnancy: Bumex should be given to a pregnant woman only if the potential benefit justifies the potential risk to the fetus.

Bumetanide may be excreted in breast milk.

Pediatric Use: Safety and effectiveness below age 18 not established.

ADVERSE REACTIONS: Muscle cramps, dizziness, hypotension, headache and nausea, and encephalopathy (in patients with preexisting liver disease).

Less frequent clinical adverse reactions are weakness, impaired hearing, rash, pruritus, hives, electrocardiogram changes, abdominal pain, arthritic pain, musculoskeletal pain and vomiting.

Other clinical adverse reactions are vertigo, chest pain, ear discomfort, fatigue, dehydration, sweating, hyperventilation, dry mouth, upset stomach, renal failure, asterixis, itching, nipple tenderness, diarrhea, premature ejaculation and difficulty maintaining an erection.

Laboratory abnormalities reported are hyperuricemia, azotemia, hyperglycemia, increased serum creatinine, hypochloremia, hypokalemia, hyponatremia, and variations in CO₂ content, bicarbonate, phosphorus and calcium. Although manifestations of the pharmacologic action of Bumex, these conditions may become more pronounced by intensive therapy.

Diuresis induced by Bumex may also rarely be accompanied by changes in LDH, total serum bilirubin, serum proteins, SGOT, SGPT, alkaline phosphatase, cholesterol, creatinine clearance, deviations in hemoglobin, prothrombin time, hematocrit, platelet counts and differential counts. Increases in urinary glucose and urinary protein have also been seen.

DOSAGE AND ADMINISTRATION:

Oral Administration: The usual total daily dosage is 0.5 to 2.0 mg and in most patients is given as a single dose.

Parenteral Administration: Administer to patients (IV or IM) with GI absorption problem or who cannot take oral. The usual initial dose is 0.5 to 1 mg given over 1 to 2 minutes. If insufficient response, a second or third dose may be given at 2 to 3 hour intervals up to a maximum of 10 mg a day.

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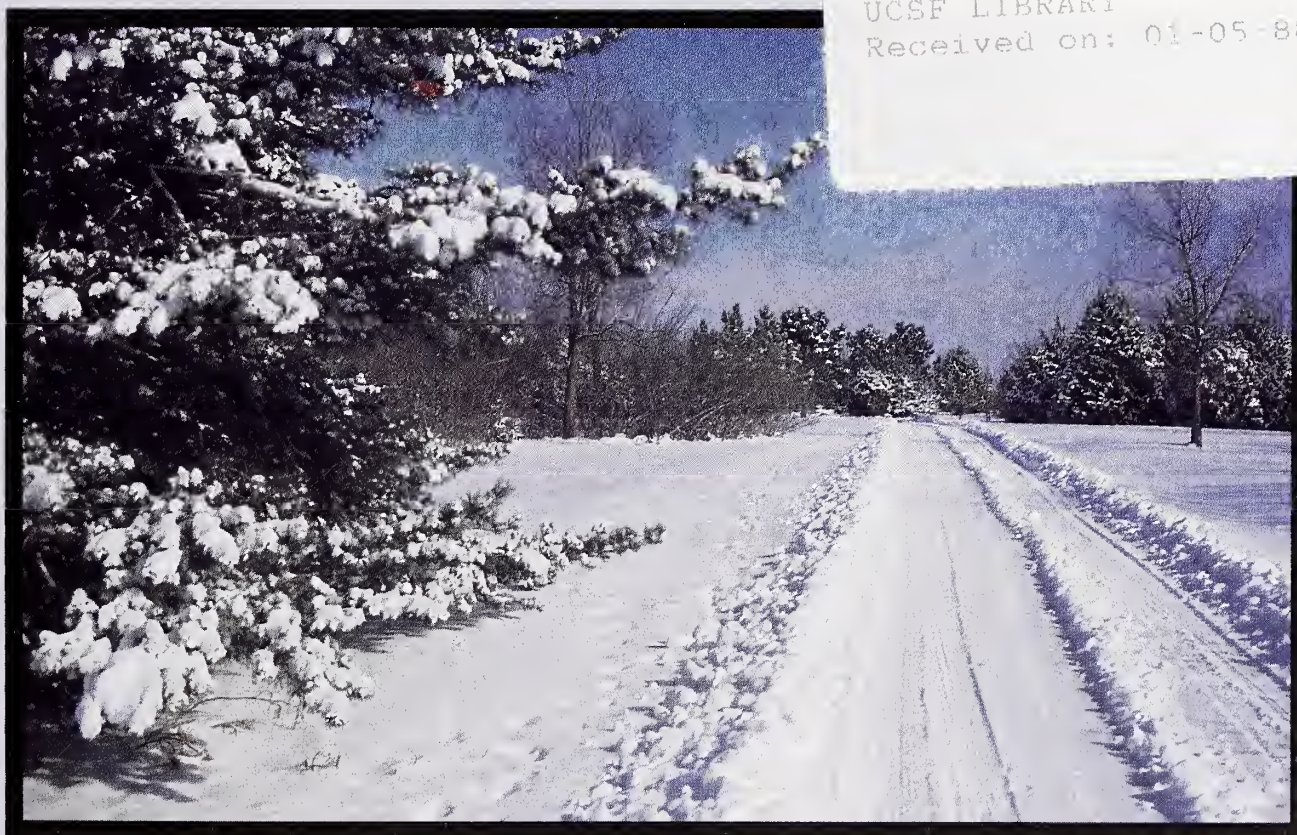
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KANSAS MEDICINE

Volume 88, Number 12, December 1987 ISSN 8755-0059

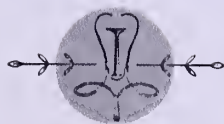
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Special Features

Maternal Health Committee: Maternal Mortality Review	338
Constitution and By-Laws	344
Index to Volume 88	365
KMS Newsletter	348a

THE JOURNAL OF THE KANSAS MEDICAL SOCIETY



KANSAS MEDICINE

• The Journal Of The Kansas Medical Society •

Volume 88, Number 12, December 1987

Contents

Special Features

Maternal Health Committee:	
Maternal Mortality Review	338
Constitution and By-Laws	344
Index to Volume 88	365

Miscellaneous

Classified Advertisements	368
Contents: Constitution and By-Laws	343
Council Meeting	336
Cover Story	331
Editorial Comment	334
Information for Authors	331
KMS Newsletter	348a
Medicina et Lex	340
Physician Directory	364
President's Message	332
Vox Dox	339

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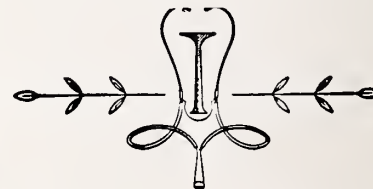
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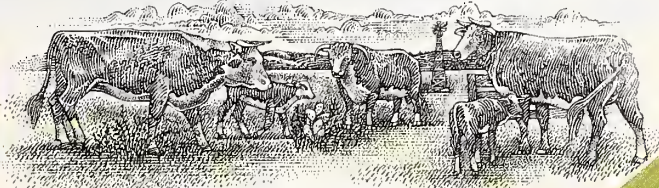
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Good News For People Who Eat.

If your taste buds are not altogether excited about a future of organic fiber flakes, the beef industry would like a few words with you. Even a few from the U.S.D.A. Because the lowdown on beef is probably less than you think—lower in calories, leaner on fat, lighter on cholesterol than you would ever imagine. It's even faster to fix than your mother knows. So read on. And hang on to your forks.

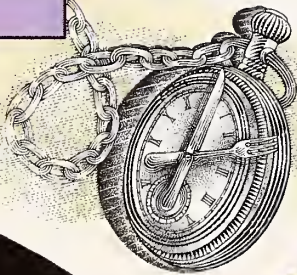


THE LOWDOWN ON CHOLESTEROL

True fact: beef has only 76 milligrams of cholesterol in a 3-ounce serving. That's only average. Wonderfully average.

GOOD NEWS FOR PEOPLE WHO COOK

No sauces, no fussing, no frou-frou. Beef doesn't need much help in the kitchen. To cut time, just cut big things in pieces. With stir-fries, sautees, kabobs and marinades, there's never a dull moment. Or a wasted one.



THIS IS YOUR BITE

3 oz. of lean beef is under 200 calories. But for that fraction of a total day's calories, you get: • 46% of the adult man's RDA for protein • 59% of the adult woman's RDA for protein • 15% of the adult woman's RDA for iron • 40% of the adult RDA for zinc • 76% of the adult RDA for vitamin B-12



THE UNSATURATION POINT

Over half the fat in beef is actually mono- or poly-unsaturated. That's why 3 ounces of tenderloin have only 3.1 grams of saturated fat out of 7.9 grams total. May your body and your taste buds make peace.



TERIYAKI BEEF STIR-FRY

Preparation: 15 min.

Cooking time: 10 min.

Cut 1 lb. top round steak in thin strips. Marinate in 3 Tbs. teriyaki sauce, 1 Tbs. oil and 2 tsp. cornstarch 30 min. Stir-fry 2 bell peppers (3/4" cube) and 6 green onions (2" pieces) in 1 Tbs. oil 3 min.; remove. Stir-fry beef (1/2 at a time) 2-3 min. Return all ingredients. Cook until hot. 4 servings.

Calories: 247 per serving; 162 from beef



Figures are for 3-ounce servings, cooked and trimmed.



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ROUND TIP

6.4 gms total fat*
(2.3 gms sat. fat)
162 calories



TOP LOIN

7.6 gms total fat*
(3.0 gms sat. fat)
172 calories



TOP ROUND

5.3 gms total fat*
(1.8 gms sat. fat)
162 calories

Beef.

Real Food For Real People.

Source: U.S.D.A. Handbook No. 8-13



EYE OF ROUND

5.5 gms total fat*
(2.1 gms sat. fat)
155 calories



TENDERLOIN

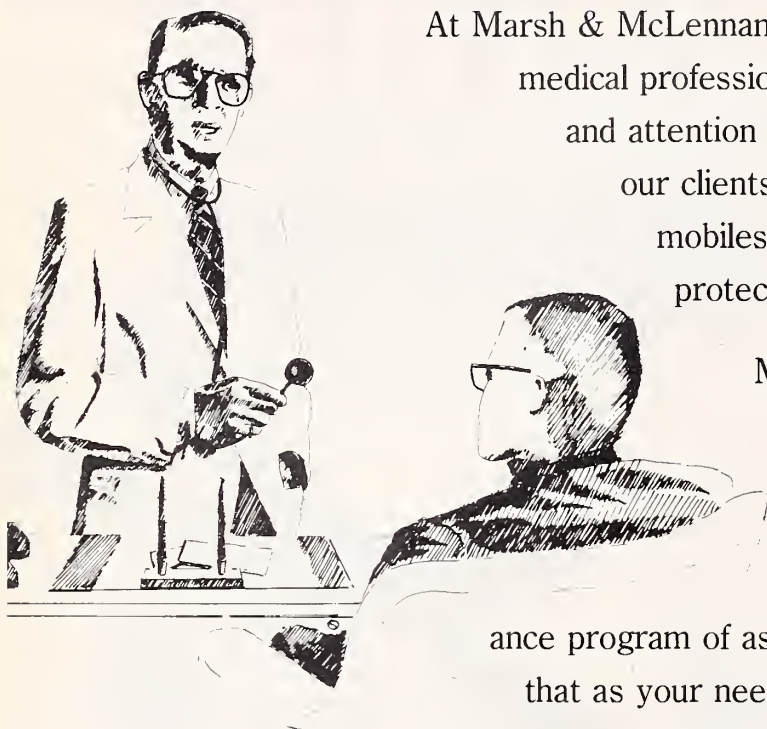
7.9 gms total fat*
(3.1 gms sat. fat)
174 calories



SIRLOIN

7.4 gms total fat*
(3.0 gms sat. fat)
177 calories

A SPECIAL CONFIDENCE



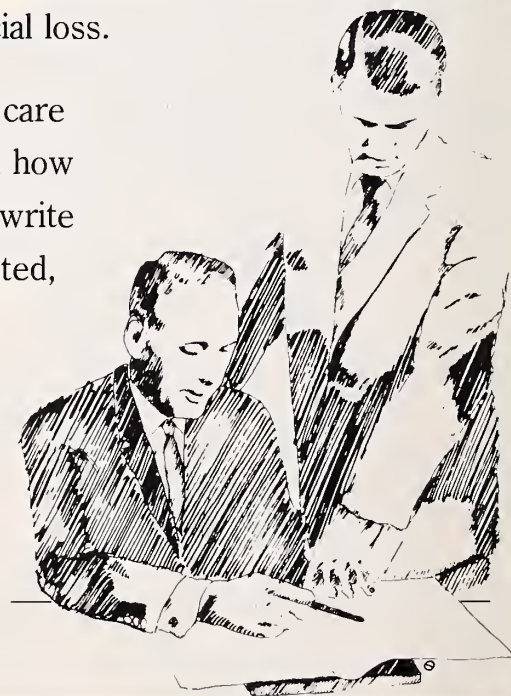
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Cover Story

THE PASSING of the Ice Age brought significant changes to the planet: seasonal changes in the weather on an annual basis — instead of over eons — and (eventually) a human population to write about them. Of the resulting seasons, winter has always received the worst press, as exemplified by Shakespeare, who reports: "And after summer ever more succeeds/ Barren winter, with his wrathful nipping cold." There is a little of both in Chet Lessenden's sunny but wintry landscape. Ralph Waldo Emerson's "mad wind's nightwork" is suggested in this month's cover, even more as Emerson continued: "The frolic architecture of the snow."

Poetic comments have varied as much as the subject, as in James Thomson's "See, winter comes to rule the varied year/ Sullen and sad." Samuel Coleridge takes a less dismal view and comes closer to the message in the picture with "Winter slumbering in the open air/ Wears on his smiling face the dream of Spring." Still, for some spring seems never to come. For example, Boris Pasternak's man in Siberia, Dr. Zhivago, who knew something about snow there, says: "It snowed and snowed the world over/ Snow swept the world from end to end."

As we approach a new legislative session, perhaps the picture would prove an admonition to the legislators, in the words of John Dyer:

A little rule, a little sway,
A sunbeam on a winter's day
Is all the proud and haughty have
Between the cradle and the grave.

Still, Thomas Campion was determined to find something good about it:

The summer hath his joys
And winter his delights
Though love and all his pleasures are but toys
To shorten tedious nights.

One can't argue with that, but Thomas Nashe remains the curmudgeon: "From winter, plague and pestilence, Good Lord, deliver us."

So winter has had its advocates and its critics — who had no awareness of the possibilities of recording its beauties in photographs. But those in climates where spring can be counted on to arrive eventually were generally united in welcoming the end of winter. As Lord Tennyson put it, lyrically:

Ring out the old, ring in the new,
Ring happy bells across the snow:
The year is going, let him go;
Ring out the false, ring in the true.

A thought for an election year.

Information for Authors

Manuscripts must be typewritten, double spaced, leaving wide margins. Submit the original plus one copy if possible. Manuscripts are received with the explicit understanding that they are not simultaneously under consideration by any other publication. Publication elsewhere will be subsequently authorized at the discretion of the editor.

Brief, concise **articles** are preferred; an ideal manuscript will not exceed five double spaced pages. All material will be edited by the staff copy editor to assure clarity, good grammar and appropriate language, and to conform to KANSAS MEDICINE style and format. When feasible, material may be condensed.

The **author** will be asked to review the galley proof prior to publication to verify statements of fact. Although editing and proof-reading will be done with care, the author is responsible for accuracy of material published.

The **galley proof** is for correction of **ERRORS**; rewriting of material must be done prior to submission. Authors are urged to carefully check manuscripts and galley proof for errors that could result in inaccurate information.

Drugs should be referred to by generic names; trade names may follow in parentheses if useful. All **units of measure** must be given in the metric system.

KANSAS MEDICINE will print a maximum of ten **references**. All applicable references should be marked by superscripts in the text in the order cited. If more than ten sources are cited, the author should designate the ten most significant to be printed, and readers will be referred to the author for the complete list.

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PRESIDENT'S MESSAGE

Why Did We Do It?

"WHY did we do it; why did we become physicians?" In thinking of my own medical school class, I remember that the students went into medicine because they wanted to work with people. They wanted to apply scientific information in a meaningful and useful manner and to do something that was of importance to humanity. Now, many of us would not recommend to our children that they become physicians because of the intrusion of government, third-party carriers and PPO arrangements that limit patient access, and HMO organizations that limit physician access.

In comparison to medicine of the past, our technology and capabilities have changed the apparent outcome of many illnesses and diseases. We have more drugs and more medical and surgical therapy than ever before, which makes our work extremely exciting and much more successful. On the other hand, we certainly have our failures, but that is no different than ever. These failures seem glaring, however, having led to an increased malpractice claim frequency based on the public perception that medical care should always have a good outcome. Our disillusion in not obtaining perfection leads to withdrawal into more secure areas of practice or to early retirement. We need to renew our lost drive and desire and once again to instill in ourselves the greatness of medicine. We can acknowledge that we work hard and long hours, but that the work is worthwhile. We constantly deal with end-stage disease, which can make us feel impotent in the face of inexorable progression of illness. We must realize and teach society that we can do little against the ravages of some illnesses. We must focus on the patient-physician relationship in our practices, as this is where the true joy exists.

Many changes are occurring in the administration of medical care, which most of us see as an intrusion into our practice. Disillusionment with the system can become overbearing, but we must accept change and learn to adapt and respond constructively. Phy-



sicians need to learn to cooperate for medicine to advance. Petty territorialism needs to be resolved for the good of our patients. Certainly the practice of medicine is humbling, and each of us needs to admit our own fallibility and develop coping mechanisms.

By focusing on the patient-physician relationship, we can find immense satisfaction in the intellectual challenge of caring for our patients. Though many of these ideas and conditions seem very idealistic, they are also realistic and obtainable. If we can learn to balance the hardships and the joys of this calling, we will be better physicians and better role models for those young people about to consider the profession of medicine.

A handwritten signature in dark ink, reading "Donald V. Hutton" followed by a stylized monogram.

President



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EDITORIAL COMMENT

Convenience or Conflict?

ONCE AGAIN, the matter of physician dispensing of drugs emerges to interrupt the professional tranquility. Though hardly a colossus in the world of medical problems, it stands with one foot firmly planted in the past, while the present seeks to guide the other to firm footing. The current discussion is born of the increasing incursion of the public into the ways and means of medical service.

The matter is, in fact, the product of ancient tradition out of necessity. In the beginning, it was the order of the day that physicians should not only diagnose the disease but prepare and dispense the therapeutic agents. Even to the not-too-distant days preceding our own, medical training was largely in the area of plant, animal and mineral products prepared by the physician, some of whom, coming on unusually successful (and patentable) combinations, profited mightily.

The output of the chemical laboratory came increasingly into the picture. The process became profitable enough to attract entrepreneurs with the ability to meet the problems of product development, merchandising, purity, advertising — even effectiveness — that emerged as specifics, isolates, and laboratory creations came into the picture. Physicians and drug companies established a comfortable mutual admiration society, supported by a system of pharmaceutical-industry willingness to provide educational opportunities (including, thank goodness, advertising revenues for medical periodicals) and “detail men” to keep the names and products before the physician and the sample drawer supplied.

The blessings of the modern age, however, have changed the scene. Physicians, distracted by public and governmental insistence to put the office in new (if not necessarily improved) order, were faced with unexpected problems which could be grouped under the heading of business. In this context came accentuation of competition in the conduct of practice. In the newly developing vernacular, this emphasized the concept of cash flow, a term which would

have perplexed our professional forefathers. Since some physicians saw that the dispensing of drugs for profit could be historically and financially justified, the practice grew sufficiently to attract public attention. It is now dignified by proposed federal regulatory action in the form of H.R. 2168.

This bill, as in the case of most regulatory proposals, is couched in terms of reasonableness (at least until the bureaucratic interpreters get their hands on it). It allows for physician dispensing of drugs in the presently accepted areas of necessity: instances when the procurement of medication elsewhere would be difficult or impossible for the patient (distance, disability, character of the medication and so on), in emergencies and at government health clinics, for example. (Or, presumably, the “starter” supplies from the sample drawer so long a tradition; the essence of the past acceptance of the system has been the lack of profit.)

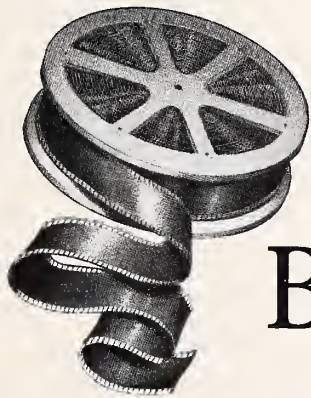
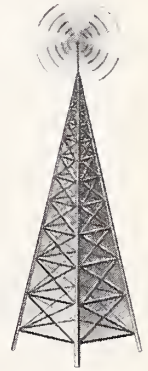
Opposition has come from various areas: the Federal Trade Commission, which sees it as restraining trade between physicians and pharmacies; the AMA, which considers it not an ethical problem but simply one better left to the states without federal interference; colleagues who consider it right and proper (at least, as *they* practice it); and other colleagues who don't like the idea. We've seen no pronouncements, but the pharmacists may well be in favor of the regulation, since it reduces competition; while the pharmaceutical industry is probably ambivalent, since it will work both sides of the street.

Needless to say, these views have been presented in lofty phraseology designed to prove the virtues of the respective positions: the desirability of helping the patient directly or indirectly (and omitting any reference to profits) and, from the other direction, the contention that there is inherently the possibility — if not certainty — of impropriety.

Our own thought may not be on such a lofty plane, but we do wonder if the profession needs yet another identification with merchandising. — D.E.G.



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government established the
Federal Radio Commission,
sound was added to the movies
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Council Meeting

Report of Meeting Held September 19, 1987

THE COUNCIL convened September 19, 1987 at the Holiday Inn Holidome, Topeka, beginning at 10:00 a.m. Donald W. Hatton, M.D., President, presided. Members present were:

Larry R. Anderson, Wellington	Richard A. Gruendel, Kansas City
Stuart C. Averill, Topeka	Donald W. Hatton, Lawrence
Mark G. Bell, Salina	Kenneth L. Knuth, Independence
Norman W. Berkley, Seneca	Warren E. Meyer, Wichita
Franklin G. Bichlmeier, Kansas City	Eugene W. J. Pearce, Shawnee Mission
F. Calvin Bigler, Garden City	Richard Preston, Great Bend
L. Theil Bloom, Pratt	Ivan E. Rhodes, Wichita
John P. Brockhouse, Emporia	Timothy M. Scanlan, Wichita
Asher W. Dahl, Colby	Joan Sehdev, Topeka
Victor M. Eddy, Hays	Richard A. Siemens, Lyons
Manis C. Edwards, Wichita	Don R. Tillotson, Ulysses
D. Mikel Elder, Topeka	Donald L. Wikoff, Great Bend
Jimmie A. Gleason, Topeka	
Modesto S. Gometz, Pittsburg — Guest	

Also present was Mrs. Phyllis Bigler, KMS Auxiliary President.

Staff present: Val Braun, Gary Caruthers, Jerry Slaughter.

Minutes of May 3, 1987 meeting were approved with the following change: The 1988 KMS Annual Meeting date is April 28–May 1.

Staff reported that the Kansas Supreme Court invalidated the **collateral source rule** by finding it unconstitutional because of the equal protection argument. Additionally, there is currently a case in Shawnee County District Court contesting the **limits on awards** adopted in HB 2661. Should the provision be overturned, it will be appealed to the Supreme Court.

Considerable discussion pertained to the current **professional liability** insurance situation in Kansas. During the past two years, the collateral source rule reduced the surcharge on the Health Care Stabilization Fund by approximately 21%. Now that the bill has been overturned, there will have to be an increase to make up for the shortages, plus interest. The surcharge on the Fund will probably increase 60–70% for 1988. In addition, most companies will increase their base rates in the 30–35% range. The cumulative increase to policyholders beginning July 1, 1988 will be 75–80%. There are several options, however, that can be utilized to improve the premium situation. These are: (1) a constitutional amendment; (2) across-the-board tort reform; (3)

abolishment of the Health Care Stabilization Fund; (4) formation of a captive KMS liability insurance company.

After considerable discussion, the Council voted to **undertake the across-the-board tort reform** and to strive for a **constitutional amendment** if such a program appeared feasible. The Council further authorized a feasibility study for the formation of a **KMS liability insurance company** and authorized a fund for this purpose. A **special assessment** for the activity in the area of professional liability was also approved. Non-members will be invited to participate in the assessment as well.

Financial reports were reviewed and approved. After considerable discussion of the budget, the Council approved an increase in the 1988 **membership dues** by \$100. At \$320, KMS dues will still rank below the median state medical society dues.

The subject of the AMA/Hartford study of **Relative Value Scale** was introduced and will be followed throughout its development.

The **Governor's Task Force on AIDS** will issue its final report to the Governor in November. Following that, KMS will develop a position prior to the legislative session. A subcommittee consisting of infectious disease specialists will be appointed to assist in development of this policy. KANSAS MEDICINE will print a special issue on AIDS.

Council members were asked to respond to a survey indicating support for the study of a **retirement program for KMS membership**.

Updates were distributed on subjects of the **Annual Meeting, Blue Shield refund, KFMC release of quality data, and the KMS Services, Inc.**

Timothy Scanlan, M.D., Medical Director of the **Impaired Physician Program** and Chairman of the **Committee for Impaired Physicians**, briefly reviewed the current status of both projects and announced that an R.N. Coordinator has been employed and is working directly with the Board of Healing Arts. The Board has turned over to the program some 18 physicians to monitor, and the program is working well.

There being no further business, the meeting **adjourned** at 12:00 noon.



Before prescribing, see complete prescribing information in SK&F CO. literature or PDR. The following is a brief summary.

*** WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin (ACTH)). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ:L42

In Hypertension*... When You Need to Conserve K⁺

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Serum K⁺ and BUN should be checked periodically (see Warnings and Precautions).



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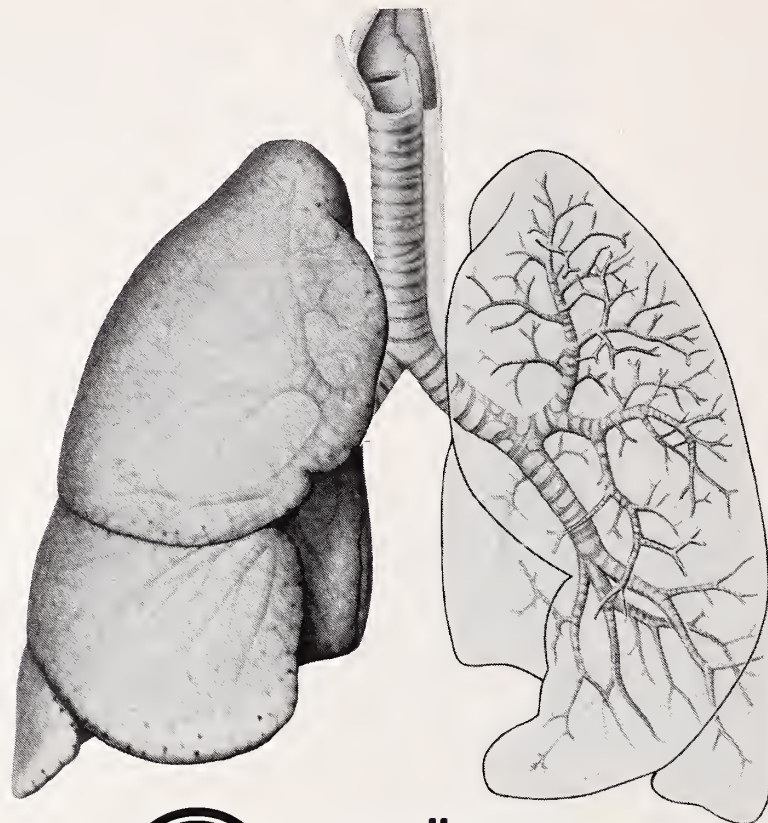
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Consider the causative organisms...



Ceclor[®]
cefactor

250-mg Pulvules[®] t.i.d.
offers effectiveness against
the major causes of bacterial bronchitis

Haemophilus influenzae and *Streptococcus pneumoniae*
(ampicillin-susceptible and ampicillin-resistant)

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Ceclor[®] (cefactor)

Summary. Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication:

Known allergy to cephalosporins.

Warnings:

CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients. Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthritis-like, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nerv-

ousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.

- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinistest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

[061787L]

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

A woman with dark hair, wearing an orange button-down shirt and dark pants, sits alone at a small white round table in a cafe. She is looking down with a somber expression. The cafe has many identical white metal chairs with heart-shaped backs and small round tables. The background is a dark, textured wall.

"Living in the city
is lonely enough...
with herpes it's like
solitary confinement."

ZOVIRAX[®] (acyclovir) CAPSULES

**Prevent genital herpes
recurrences
month after month with
daily therapy.**

(In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.)

*Please see last page of this advertisement for
brief summary of prescribing information*

ZOVIRAX[®] **(acyclovir)** **CAPSULES**

**Help free your
patients from
recurrences.**

Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks — month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

Generally well tolerated

Daily therapy with ZOVIRAX CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/vomiting, vertigo, and arthralgia.

The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

*Please see brief summary of
prescribing information on next page.*



Prevent recurrences
month after month*

ZOVIRAX[®] (acyclovir) CAPSULES

Brief Summary

INDICATIONS AND USAGE: Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psycho-social difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

First Episodes (primary and nonprimary infections—commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

Recurrent Episodes:

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

CONTRAINDICATIONS: Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

WARNINGS: Zovirax Capsules are intended for oral ingestion only.

PRECAUTIONS: General: Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS—Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

Drug Interactions: Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F₁ generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a

maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days post-dose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS—Short-Term Administration: The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

Long-Term Administration: The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

Chronic suppressive therapy for recurrent disease: One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

Intermittent Therapy: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

Patients With Acute or Chronic Renal Impairment: One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance ≤ 10 ml/min/1.73/m².

HOW SUPPLIED: Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200" - Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.

Burroughs Wellcome Co., Research Triangle Park, North Carolina 27709



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Maternal Health Committee

Maternal Mortality Review

The review appearing hereafter was authorized by the Secretary of the Department of Health and Environment pursuant to K.S.A. 65-177.

This study, and the publication of this review, is for the purpose of medical research only. The review is retrospective in nature and is not intended to address the issue of the appropriateness of the care rendered in specific cases. In some instances, the description of the case represents a compilation of several similar cases reviewed by the Committee.

Case #8508-4

THIS CASE was studied only because the patient was a Kansas resident. She was a white, 20-year-old, G2P1 who had moved to a New York town in response to an advertisement by a lawyer offering care and delivery in return for giving the child up for adoption. The only information available was derived from local press reports. She apparently had some prenatal care, but none was known to have accompanied the episode leading to death. She died shortly after first reporting respiratory distress, and the autopsy revealed bronchopneumonia and pulmonary emboli originating in the legs. She had reported in a phone call to her mother the evening before her death that she had trouble walking but apparently did not seek care until just prior to death.

Decision: Avoidable. Patient responsibility on basis of failure to pursue care available (limited information noted). The attorney who sponsored the adoption service agreed to discontinue it in return for state's agreement not to prosecute.

Case #8511-2

The patient was a white, 21-year-old G1P0 who died from septicemia following prolonged labor (5 days) with ruptured membranes. The patient had no prenatal care and was seen in labor by an independent lay midwife, who was able to deliver the head but could do no more. (Supposed religious convictions prohibited delivery outside the home, and physician care.) When seen by a physician in the hospital, the patient was in critical condition, but Cesarean section offered the only hope of survival. During the procedure, a 12-pound, stillborn male was delivered, but the patient died from cardiac arrest during the surgery.

Decision: Avoidable death. Combined patient and midwife responsibility. (The case prompted the

Committee to make increased efforts through the KDHE and KMS Committee Legislation to provide necessary control of non-medically supported midwifery.)

Case #8506-3

The patient was a white, 24-year-old primigravida with an uncomplicated pregnancy until six months, when she experienced urinary tract infection. Complaints were thought to be generally consistent for about three weeks, when she became severely ill and was believed to have endocarditis or pulmonary hypertension (patient's mother had died of this at age 23). The patient was hospitalized but immediately transferred to a Level III institution, where she died ten hours later. Prenatal care was considered good, and hospital care was intensive (including extensive discussion at CPC).

Decision: Avoidable (but responsibility not assigned because of reflection of lack of definitive treatment for severe primary pulmonary hypertension).

Case #8611-1

The patient was a white, 32-year-old G4P3 whose previous pregnancies and deliveries had been normal. The pregnancy was normal, with labor starting ten days after the anticipated date and one failed attempt toward induction. The first stage of labor proceeded without difficulty, but the second stage was delayed by fetal size and shoulder dystocia. An apparent Erb's paralysis occurred. There was technical delay in effecting episiotomy repair and excessive bleeding. Clinical evidence of blood loss developed, but the patient and her husband were Jehovah's Witnesses, precluding blood replacement. Hysterectomy was determined to be the only effective means of control of the blood loss. She survived the surgery but died eight hours postoperative in respiratory arrest. Autopsy revealed the subendometrial myometrium as the site of the bleeding.

Decision: Avoidable. Physician responsibility on circumstantial evidence. (High-risk pregnancy because of religious factor, which should have prompted more vigorous action.)

Case #8509-1

The patient was a white G2P1, age 26, with marked

hearing impairment (probably due to maternal rubella during her gestation). First pregnancy was terminated by section at term after 24 hours with ruptured membranes and no contractions. Current pregnancy normal with elective section planned. This was carried out without difficulty. The uterus evidenced atony. Limited medical efforts and light curettage were ineffective in controlling bleeding. The patient was essentially unresponsive from that time on, with increasing evidence of disseminated intravascular coagulation, including evidence of pulmonary emboli and a CT brain scan revealing left-cerebral infarct. An EEG on the first postoperative day indicated brain death, which was confirmed by additional tests on the second and third days. She had been placed on the ventilator at the time of curettage and remained on it at the time she was declared dead on the third day.

Decision: Avoidable. Physician error in failing to treat uterine atony with larger amounts of intravenous oxytoxins or prostaglandins.

VOX DOX

To the Editor:

Dr. James Lee has called my attention to an error I made in "A History of Orthopedic Surgery at UKSM-KC" (July 1987).

Dr. Donald Rose did not come to KU until about 1946, instead of the thirties, as I had written.

W. David Francisco, M.D.

School of Medicine

Department of Surgery, Orthopedic Section

University of Kansas School of Medicine

39th & Rainbow Boulevard

Kansas City, Kansas 66103

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MEDICINA ET LEX

Birth Defect Suits: Their Causes

WAYNE T. STRATTON, J.D., *Topeka**

THE DEVELOPING FETUS is subject to many factors which may affect the health of the infant. Genetic, teratogenic and developmental anomalies account for the great majority of imperfect newborns. Moreover, it is apparent that many causes are as yet unknown. A determination of the cause or causes of an infant's condition requires a detailed study of family history, environmental factors, and the events of the pregnancy, birth and the postnatal period.

Recent studies are demonstrating that few infants born depressed are in such condition because of any events at birth. The National Institute of Child Health and Human Development study begins:

If we believe that we should teach only what we know to be true, as opposed to what we know to be myth, then much of what we "know" about pre- and perinatal causes of cerebral palsy, mental retardation and epilepsy would no longer be taught. Over the past two decades, few areas in medicine have changed as rapidly as those of obstetrics and neonatology. Yet, many of our assumptions about the factors associated with brain disorders, such as cerebral palsy, mental retardation and epilepsy, remain rooted in outdated knowledge.

Too often, physicians fall into the same mind-set as laypersons: that the existence of cerebral palsy or mental retardation must result from perinatal events. The above study noted that there were 850,000 children with mental retardation and 750,000 with cerebral palsy in the United States. The fact that these numbers have remained constant despite great improvement in perinatal mortality casts doubt upon the cause-and-effect relationship.

Another common misconception is the relationship of low Apgars and cerebral palsy. Seventy-three percent of children who develop cerebral palsy had a 5-minute Apgar greater than or equal to 7. Conversely, the incidence of CP among term new-



borns with a 5-minute Apgar of 0-3 is only 1% if the 10-minute score improves to 4 or greater.

One study followed 23 children with a 1-minute Apgar of 0 (7 were considered stillborn; the other 16 did not establish respirations by 20 minutes after birth, but all were revived). The physician found 17 of the 23 to be without major neurological deficits several years later and 20 of the 23 to have an IQ score in the normal range. Another study found 29 of 31 children who had a 1-minute Apgar of 0 and a 5-minute score of less than 4 to be free of neurologic handicap at 5 to 10 years of age.

It is also interesting to find from another study that 77% of the children with abnormal fetal heart patterns were born with a normal pH value.

R. S. Illingworth said it best:

It is simplistic, irrational and naive to ascribe cases of mental subnormality, cerebral palsy, or other features of 'brain damage' to birth, just because birth, always dangerous, is one possible factor, or just because some aspect of management can be criticized, though many would regard it as acceptable. It is not sensible to blame the obstetrician or midwife, without considering all the other possible factors which might have caused or greatly aggravated the difficulties of delivery.

From the foregoing, it may be seen that the causes of birth defects are often unknown and frequently misunderstood. All health care providers involved in the delivery or care of the newborn must appreciate this fact in order to deal with risk-management techniques, which will be discussed in the next article (January 1988).

*KMS Legal Counsel.

Comments appearing herein are not intended as a substitute for legal analysis or advice. Answers to legal questions depend largely upon the particular facts of a case. The reader is urged to consult an attorney for answers to specific legal questions.

These comments do not necessarily represent the views of KANSAS MEDICINE, or the Kansas Medical Society. For further information, contact Mr. Stratton, 215 E. 8th, Topeka KS 66603, 1-800-332-0248.



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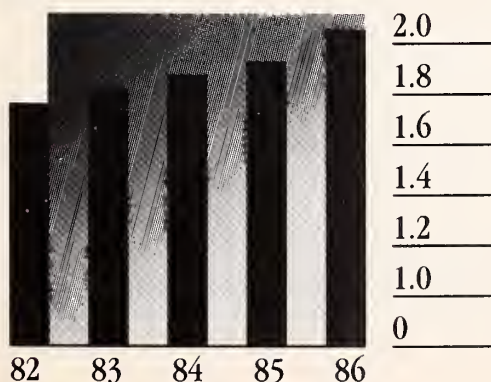
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COMPREHENSIVE DIAGNOSIS, TREATMENT AND CONTROL

Information for Authors

Manuscripts must be typewritten, double spaced, leaving wide margins. Submit the original plus one copy if possible. Manuscripts are received with the explicit understanding that they are not simultaneously under consideration by any other publication. Publication elsewhere will be subsequently authorized at the discretion of the editor.

Brief, concise **articles** are preferred; an ideal manuscript will not exceed five double spaced pages. All material will be edited by the staff copy editor to assure clarity, good grammar and appropriate language, and to conform to KANSAS MEDICINE style and format. When feasible, material may be condensed.

The **author** will be asked to review the galley proof prior to publication to verify statements of fact. Although editing and proof-reading will be done with care, the author is responsible for accuracy of material published.

The **galley proof** is for correction of ERRORS; rewriting of material must be done prior to submission. Authors are urged to carefully check manuscripts and galley proof for errors that could result in inaccurate information.

Drugs should be referred to by generic names; trade names may follow in parentheses if useful. All **units of measure** must be given in the metric system.

KANSAS MEDICINE will print a maximum of ten **references**. All applicable references should be marked by superscripts in the text in the order cited. If more than ten sources are cited, the author should designate the ten most significant to be printed, and readers will be referred to the author for the complete list.

Illustrative material must be identified by its referral number in the text and be accompanied by a short legend. **Photos** should be black and white glossy prints. **Tables** should be self-explanatory and should supplement, not duplicate, the text.

KANSAS MEDICINE will assume the cost of B/W engravings, cuts, and tables for two units. A unit is defined as 1/4 page. The author(s) will be billed for additional units at a cost.

A **reprint** order form with a table showing estimated cost will be sent with the galley proof. Reprints must be ordered by the author through KANSAS MEDICINE, and will be billed to the author following shipment of the order.

CONTENTS: Constitution & By-Laws

Act of Incorporation	344
Charter Declared Valid	345
Articles and Amendments	346
By-Laws:	
Amendments	362
Annual & Special Sessions	348
Assessments	348
Committees & Commissions	359
Component Societies	360
Council	357
Editorial Board	360
General Meetings & Sections	348
House of Delegates	350
Medical Ethics	362
Membership	347
Officers, Duties	355
Officers, Elected	353
Official Policy Statements	362
Rules of Order	362

CONSTITUTION and BY-LAWS

Kansas Medical Society

May 1986

ACT OF INCORPORATION

An Act to Incorporate the Kansas Medical Society

Be it enacted by the Governor and Legislative Assembly of the Territory of Kansas:

Section 1

Amory Hunting, S. B. Prentiss, J. P. Root, A. Fuller, C. F. Kobb, J. W. Robinson, J. B. Wheeler, L. C. Tolles, S. C. Harrington, A. Danford, C. E. Minor, J. B. Woodward, W. Madison, J. H. Phelps, O. Brown, Charles Robinson, M. F. Holladay, H. J. Canniff, A. J. Ritchie, M. Baily, J. M. Pelot, H. H. Beals, J. G. Blunt, T. Linsey, G. W. Beaumont, J. Leigh, A. Newman, H. Hartmann, Wm. Graham, and their associates and successors, who shall be elected to membership as hereinafter provided, are hereby constituted a body corporate and politic by the name of the Kansas Medical Society, and shall have perpetual succession forever. Said Society may have a common seal, and change or alter the same at pleasure.

Section 2

That members of said Society, in their corporate capacity, may elect such officers as they shall judge necessary for its government and the management of its affairs, determine the name, power, duty and term of office of each, also the time and manner of said elections.

Section 3

Said Society, by and in their corporate name, may have all the rights, privileges, and powers of a natural person in law and equity.

Section 4

Said Society may elect such persons to membership as they shall judge proper, and shall have power to expel, suspend, or disfranchise the same, as members, from all the rights and privileges of the Society; but such expulsion, suspension, or disfranchisement shall be by a vote of two-thirds of all the members present at a regular meeting of said Society, of which due notice shall have been given.

Section 5

Said Society shall have full power to make and enforce by-laws, and impose and collect at law any reasonable fines, not exceeding fifty dollars, as may be provided in said by-laws, for any and every violation or infraction thereof.

Section 6

Said Society shall issue certificates of membership to all its members, under such regulations as its by-laws may prescribe, and may also grant licenses to all respectable physicians, non-graduates,

who shall, on examination, be found qualified for the practice of medicine and surgery, or either, to practice those branches for which they are found qualified.

Section 7

Any three members of said Society may organize county or auxiliary societies in any county of this Territory; and said auxiliary society, when so organized, shall have all the powers and privileges, in the corporate name which they may adopt, that are conferred, by this act upon the Kansas Medical Society; and the officers of said auxiliary societies shall be honorary members of the Kansas Medical Society.

Section 8

A meeting of the corporators, or a part thereof, shall be held in Lawrence, on February 10, A.D., 1859, for the purpose of electing the first officers and completing the organization.

Section 9

This act to take effect and be in force from and after its passage.

C. W. BABCOCK
President of the Council
Approved February 10,
1859

A. LARZELERE
Speaker of the
House of
Representatives
S. MEDARY, Governor

CHARTER DECLARED VALID 1881

In 1880 a lawsuit reached the Supreme Court of Kansas contending in part:

“1. That the charter of the Society has expired by statutory limitation;

“2. That the power of the territorial legislature, being permissive and temporary only, could confer no invested right, by contract or otherwise, which would bind the state against its consent;

“3. That the charter of the Society was granted by a territorial act, not accepted or preserved by the state; and

“4. That the legislature did not and has not the power under the constitution to recognize or validate the existence of the Society, nor to grant it additional powers by the act of 1879. . . .”

In the January term, 1881, in the case, STATE OF KANSAS ex rel. v. D. W. Stormont and others, the Supreme Court of the State of Kansas, with all justices concurring, said in part:

“The Society was incorporated, by a special act of the territorial legislature, on the 10th day of February 1859. . . .” *It is, “ . . . hereby constituted a body corporate and politic, by the name of the ‘Kan-*

sas Medical Society,’ and shall have perpetual succession forever. It is conceded that the legislature of the territory had the power to incorporate the Society by a special act. Having the power to create the corporation, it had the further power to endow it with all the attributes of a corporation, not inconsistent with the provisions of the Constitution of the United States, and the act organizing the territory of Kansas, approved May 30, 1854. . . . Therefore, within this definition, immortality is a legitimate attribute to be conferred on a corporation. . . . When not limited or forbidden by constitutional or organic law, the right to confer perpetual succession by legislative authority, so far at least as human agency can confer such an attribute, cannot be logically questioned. . . . This much is clear: The charter did not expire by the law of 1855.

“Our conclusions upon the foregoing matters are that the Kansas Medical Society was lawfully chartered by the territorial legislature; that it was legally endowed with perpetual succession forever; that the constitution did not suspend or repeal its charter; that, if the state legislature has the power to suspend or repeal the charter (which we do not decide) it has never exercised, or attempted to exercise, the power; and that the Society is a lawfully existing corporation.”

CONSTITUTION

ARTICLE I — Title and Definition

The name of this organization is THE KANSAS MEDICAL SOCIETY. The SOCIETY is comprised of the Component Societies chartered by this organization.

ARTICLE II — Objects

The object of this SOCIETY is to unite the medical profession of the State of Kansas in promoting the science and art of medicine and protecting the health of the citizens of this State.

ARTICLE III — Component Societies

County or multi-county societies holding a charter from this organization are known as Component Societies.

ARTICLE IV — Members

The KANSAS MEDICAL SOCIETY is composed of members of the Component Societies and others as provided in the By-Laws.

ARTICLE V — House of Delegates

The House of Delegates is the primary legislative and governing body of this SOCIETY. The members of the House of Delegates will be elected by the Component Societies as provided in the By-Laws. This body will transact the business of the SOCIETY and will elect officers except as otherwise provided in the By-Laws.

ARTICLE VI — Officers

The officers of this SOCIETY are a President, a President Elect, a First Vice President, a Second Vice President, a Secretary, a Treasurer, a Speaker and a Vice Speaker of the House, Delegates and Alternate Delegates to the American Medical Association. The terms of office, qualifications, and method of election shall be provided in the By-Laws.

ARTICLE VII — Council Districts and the Council

The boundaries of the Council Districts shall be specified in the By-Laws. The Council consists of one Councilor from each Council District, the officers of the SOCIETY, and advisory members as designated in the By-Laws. The Council may transact business of the SOCIETY between sessions of the House of Delegates subject to the approval of that body and as prescribed in the By-Laws.

ARTICLE VIII — Meetings

The SOCIETY will hold an annual meeting for the presentation and discussion of subjects pertaining to the science and art of medicine. The House of Delegates shall convene at the annual meeting and at other times as necessary for the transaction of the business of the SOCIETY. The place of the annual meeting shall be approved by the House of Delegates, following a recommendation of the Council.

ARTICLE IX — Funds, Dues, Assessments

Funds for the functioning of this SOCIETY shall be raised by an equal annual dues or by assessment of the Members who are subject to these charges as provided in the By-Laws. The amount of dues and assessments shall be determined by the Council and approved by the House of Delegates.

ARTICLE X — Seal

The following insignia shall be the official seal of this SOCIETY:



The official seal shall at all times remain in the custody of the Secretary.

Amendments to Constitution

ARTICLE XI — Amendments

Amendments to this Constitution require an affirmative vote of two-thirds of the Delegates present provided the question has been introduced at the previous annual session, or upon recommendation by the Council and published twice in KANSAS MEDICINE, or submitted by the Council to each Component Society at least two (2) months in advance of the meeting.

BY-LAWS

1.0 MEMBERSHIP

1.1 Each component society shall judge the qualifications and classify its own members. When names are submitted on a properly prepared roster to the state office along with payment of the full annual assessment to the Kansas Medical Society, if required by their classification, the listed physicians shall become members of the Kansas Medical Society, and they shall remain so as long as they are members in good standing in their component societies and the dues to the Kansas Medical Society remain paid, provided that

1.11 Every active member of the Society shall fulfill the requirements of postgraduate medical education set forth by the Commission for Education of the Kansas Medical Society.

1.111 Out of State members shall be exempt from the continuing medical education requirement.

1.2 Before a charter is issued to any component society, ample and full opportunity to become a member shall be given to every physician residing or practicing in the area encompassed by that society.

1.3 Every qualified physician shall be privileged to apply for membership in an established component society encompassing his/her area of practice.

1.4 When a member's practice is interrupted by an authorized absence, his dues will not be refunded except upon recommendation by the component society to which he belongs.

1.5 Members may attend an annual session after first registering and being verified.

1.6 Classification of members

1.61 Members with the right to vote and hold office:

1.611 Members who pay full dues. Members of a component society who hold a degree of Doctor of Medicine, Doctor of Osteopathy, or their equivalent, and are fully licensed to practice medicine and surgery by the Kansas State Board of Healing Arts.

1.6111 Active Members (1st year) — Physicians in their first year of full time medical practice after completing their residency requirements. They shall pay 50% of regular dues and assessments the first full dues year.

1.61111 Active Members (2nd Year): Physicians in the second year of full-time medical practice shall pay 75 per cent of regular dues and assessments for the second full dues year.

1.612 Dues-Exempt Members: Component societies may designate members to be excused from paying dues in these categories:

1.6121 Personal Exemption: Members for whom extended illness or financial limitations create genuine difficulty in paying the dues.

1.6122 Retirement: Members who have retired from active practice. Members in this category may hold an inactive license to practice medicine and surgery. Retirement status will not be available to physicians who assume compensated positions in the health care field after retiring from medical practice.

1.6123 Service: Members temporarily serving with the armed forces except as provided in 1.7.

1.6124 Emeritus: Members over seventy (70) years of age, with dues-paying status for ten (10) years or more may apply for this category, or elect to retain active membership.

1.6125 Probationary Members: Upon certification by the secretary of a component society that a member has been accepted on a probationary basis, the Kansas Medical Society will place his name on the membership rolls. The probationary member will receive the *Journal* and all other correspondence forwarded from the state office. He may serve on committees and commissions but is not eligible to serve as a state or AMA delegate, councilor, or officer. One-half regular dues will be assessed during this period. This category of membership terminates when the component society either votes him into active membership or drops him from their membership rolls.

1.6126 Interns and Residents engaged in full-time training shall be given full privileges of membership including the right to vote and hold office and be assessed annual dues of ten dollars (\$10.00).

1.6127 Medical Students shall be given full privileges of membership including the right to vote and hold office, and be assessed no annual dues.

1.6128 Military Service — Physicians on full-time active duty with the military service. They shall pay fifty per cent (50%) of the regular KMS dues and assessments. They shall have the right to vote, but will not be eligible to hold office.

1.62 Members with full privileges except for the right to vote and hold office. They apply for membership through a component society but are assessed less than the full amount of dues:

1.623 Associate Members: Physicians who are

active members of another state medical society and wish to affiliate with the Kansas Medical Society. They shall pay fifty per cent (50%) of the regular dues and assessments.

Oral surgeons with hospital staff privileges, and membership in their respective local, state and national organizations. They shall pay fifty per cent (50%) of the regular KMS dues and assessments.

1.63 Honorary Members: Persons outside the membership of this Society may be designated Honorary Members by a majority vote of the House of Delegates. They pay no dues and may not vote or hold office:

1.631 Members of the medical societies of other states or of foreign medical societies recognized by the American Medical Association.

1.632 Physicians from Kansas, having graduated from an accredited school of medicine, and who are serving outside the United States as missionaries or in education or philanthropic work.

1.633 Non-physicians, whether Kansans or not, who have made an outstanding contribution to the Kansas Medical Society or to the field of Medicine in general.

1.634 Physicians from the membership of this Society are named for notable achievement in the field of medicine or extraordinary service in the interest of this Society. They are granted Honorary status by a vote of the House of Delegates and pay no dues, but if they were previously voting members, retain the right to vote and hold office.

1.7 Leave of Absence: Leave of absence is granted any member for the period specified by the secretary of his component society, in written certification to the secretary of this Society, excepting that an absence shorter than six (6) months will not alter his previous status. A member on leave of absence for more than six (6) months is exempt from payment of dues in any full six (6) months of absence calculated from 1 January and 1 July, upon certification by his component society.

1.71 Dues will not be exacted from the member on leave at the time they become payable. If he is absent for a full year or more, the prepaid dues will be applied to the year of his return.

1.72 A leave of absence exceeding one year, calculated from the first certification in the annual report of membership, must be recertified in each subsequent annual report, or until notification of reinstatement (or discontinued membership) is received from the component society.

1.8 Dues Refund: Refunds of one half (½) mem-

bership dues will be considered on an individual basis upon application to the Executive Committee prior to July 1.

1.81 One-half Year Memberships: One-half year memberships will be considered on an individual basis upon application to the Executive Committee.

2.0 ASSESSMENTS

2.1 The amount of the annual assessment for the Kansas Medical Society only shall be determined by the Council after consideration of the annual budget for the ensuing year and announced to the various component societies not less than sixty (60) days before the beginning of each fiscal year. Such assessments shall be levied against and paid by the component societies in the manner provided by this Constitution and By-Laws, except that any new member of this Society being accepted by a component society after July 1, shall be assessed one-half the annual sum decided upon by the Council, and shall be accorded all the rights and benefits of this Society, including defense, until the succeeding January 1.

2.2 Assessments shall include subscription to KANSAS MEDICINE at a rate determined by the Editorial Board with the approval of the Council.

2.3 Special assessments may be levied as needed. Request for special assessments will be referred to the Council for study, whereupon the Council shall make a recommendation to the House of Delegates for final action. All special assessments are mandatory upon all full dues-paying members unless otherwise specified.

3.0 ANNUAL AND SPECIAL SESSIONS

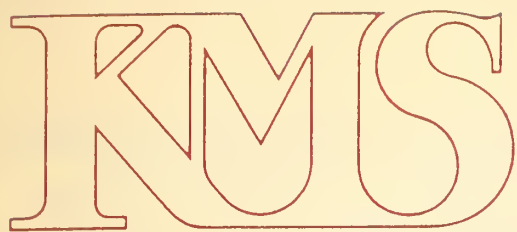
3.1 The Society shall hold an annual session at the time and place determined by the Council at the preceding annual session. The date and location of the annual session may be changed by the President subject to the approval of the Council. *Provided:* that each component society is notified of the change at least five (5) weeks before the new date.

3.2 Special meetings of the Society may be called by the President upon approval of the Council.

4.0 GENERAL MEETINGS AND SECTIONS

4.1 The Scientific Assembly at the annual sessions may be divided into general meetings and sections by the local Committee on Arrangements with approval of the Committee on State Meeting Format.

4.2 The general meetings and sections of the Society shall be devoted to scientific work together



KANSAS MEDICAL SOCIETY Newsletter

1300 Topeka Ave. • Topeka, Kansas 66612 • (913) 235-2383

DECEMBER 1987

MALPRACTICE UPDATE

The 1988 Legislative Session will convene January 11, and it promises to be filled with controversy. KMS and the Kansas Hospital Association will press for changes in tort reform legislation in order to answer constitutional problems outlined by the Kansas Supreme Court. Additionally, KMS is evaluating the feasibility of phasing out or abolishing the Health Care Stabilization Fund, as well as the mandatory requirement that physicians and hospitals carry medical malpractice insurance.

In an effort to stabilize rates and open up the severely restricted market, KMS also continues work on the feasibility of establishing its own professional liability insurance company. An 85% rate increase requested by Medical Protective is still pending, and the other major insurance carriers are expected to file increases sometime early in 1988.

As the legislative session draws closer, opposition to our plans appears to be intensifying. The Kansas Bar Association and the Kansas Trial Lawyers Association are expected to oppose virtually all of the suggested reforms which have the potential of significantly impacting awards and malpractice premiums. The KTLA (which, for all practical purposes controls the KBA) will oppose reform efforts on the grounds that a malpractice crisis does not exist, and that the cause of the "problem" is bad doctors and greedy insurance companies.

By now every KMS member will have received mailings which outline the proposals KMS is asking the Legislature to consider. Additionally, as patient educational materials are mailed, you are encouraged to participate and help the overall public education effort. Continue to watch your mail for details, and if you have any questions please contact the KMS office at 1-800-332-0156.

During its meeting of December 5, the State Board of Healing Arts adopted regulations governing issuance of exempt licenses to physicians. The exemption pertains to mandatory liability insurance coverage and participation in the Health Care Stabilization Fund, but does not provide immunity from liability. A last-minute amendment was adopted which prohibits exempt licensees from prescribing controlled substances. An earlier version of the regulations would have prohibited exempt licensees from writing any prescriptions at all, but KMS opposed that restriction.

Exempt license application forms should be available in January 1988 from the Board of Healing Arts.

In This Issue...

- Malpractice update
- Exempt license regulations adopted
- Medicare:
Preferred M.D. list
- Organ donation
- DNA fingerprinting:
new identification tool
- Names of AIDS patients not reportable
- MAAC warning letters
- Help wanted:
Executive Director,
Kansas State Board
of Healing Arts
- Legislative panel
concludes hearings on
state health benefits
- Happy holidays
- KMS-IPP conference

EXEMPT LICENSE REGULATIONS ADOPTED

MEDICARE:
PREFERRED M.D. LIST

KMS and the AMA are carefully monitoring, with great concern, the latest Reagan Administration's draft Medicare policy. Under this policy, Medicare will pay more of patients' bills if they go to doctors who make special efforts to eliminate unnecessary services. But beneficiaries would get no discount and might have to pay more of the bills if they see physicians with a history of what the government considers excessive tests, office visits or medical procedures.

The government would publicize names of "preferred providers." These doctors would agree not to charge Medicare patients more than the amounts approved by the government. Overall, Medicare benefit payments rose to \$76 billion last year.

Dr. William Roper, head of the Medicare agency, said the administration was determined to come up with a proposal that would save "a significant amount of money." The proposal will be submitted to Congress with the president's budget in January.

ORGAN DONATION

In October, a new federal law went into effect requiring hospitals to identify patients who could donate their kidneys, livers, hearts or lungs to people in need of such organs.

The new law, designed to increase donations of transplantable organs, was a little-noticed part of the Omnibus Budget Reconciliation Act of 1986. Under the law, organs will be distributed according to uniform criteria that set priorities for deciding who should get them. These include medical need, time spent waiting for a transplant, proximity of a donor to a recipient and, in some cases, the compatibility of the recipient and donor's genetic profiles.

Under the law, hospitals may not participate in Medicare or Medicaid unless they establish "written protocols for the identification of potential organ donors." About 97% of the nation's public and private hospitals accept Medicare and/or Medicaid patients. All hospitals where organs are transplanted will have to be members of a national organ-sharing network that is to be run, with federal funds, by the United Network for Organ Sharing of Richmond, Virginia.

DNA FINGERPRINTING:
NEW IDENTIFICATION
TOOL

A new test has been developed to establish a person's identity. Called DNA Fingerprinting, it is the first "yes-no" test for human identification, with broad applications in solving rape, murder, immigration and paternity cases. Developed by British scientist Dr. Alec Jeffreys, the test is simple to use and yields accurate results. It is now being marketed in the United States.

NAMES OF AIDS PATIENTS
NOT REPORTABLE

The November 6 issue of JAMA included an article which stated that the names of persons who test positive for the presence of the HIV antibody are reportable in Kansas. This is not correct. According to the Department of Health and Environment, clinical AIDS is reportable in Kansas, but the names of patients are not.

MAAC WARNING LETTERS

HCFA has instructed Medicare carriers to release notices of potential MAAC violations to individual physicians. Nationwide, approximately 5% of non-participating physicians will be issued notices of potential MAAC violations. Letters may be delayed in a handful of states pending HCFA review of the implementation of monitoring instructions by local Medicare carriers. In these states, the number of potential violations is significantly higher than the national average.

HCFA has raised the cumulative threshold from \$500 to \$700. In cases where MAACs have been adjusted due to calculation errors, the carriers are to monitor charges only after the date of the corrected MAAC. Due to the delay in implementing monitoring, except in extreme cases, a physician will not be referred to the Inspector General if his or her charge is reduced to or below the MAAC limit for the rest of the year.

Physicians who receive notices of potential MAAC violations should immediately send a written response to their local carriers and provide documentation if the MAAC calculations are in dispute.

HELP WANTED: EXECUTIVE DIRECTOR, KANSAS STATE BOARD OF HEALING ARTS

The Kansas State Board of Healing Arts is seeking a qualified applicant for the newly created position of Executive Director. The person selected will have responsibility for overall supervision of all aspects of the Board's functions.

To be considered for the position, an applicant must be a graduate of an approved school of allopathic or osteopathic medicine; hold or be eligible to hold an unrestricted license to practice medicine and surgery in Kansas; have 10 years of recent clinical experience in providing or directing patient care; and have at least 5 years of considerable administrative and supervisory experience. It is essential that the applicants have a broad-based knowledge of the healing arts and other allied health professions. Salary is negotiable based upon experience and qualifications.

To apply, send a current C.V., 2 professional references, and salary requirements by December 31, 1987 to Cameron D. Knackstedt, D.O., President, Kansas State Board of Healing Arts, Landon State Office Building, 900 S.W. Jackson, Suite 553, Topeka, KS 66612-1256.

LEGISLATIVE PANEL CONCLUDES HEARINGS ON STATE HEALTH BENEFITS

On December 2 and 3, the Special Committee on Ways and Means conducted extensive hearings on the state employee health care benefits contract. The committee received testimony from 16 different conferees, including a representative of the Kansas Medical Society.

Representatives of the State Employees Health Care Commission and their consultants defended the new program, which goes into effect on January 1, 1988, as did representatives of Blue Cross and Blue Shield. The emphasis focused on losses experienced by the insurer during recent years and the perceived need to institute managed care concepts in the program.

Representatives of employee groups complained about the additional costs to employees, particularly for family coverage. Another major complaint pertained to the new restrictions limiting the employee's choice of physicians.

The KMS testimony explained that originally, physicians eligible to participate under the Blue Select primary care option were required to be existing participants in a health maintenance organization. This requirement was dropped after the Blue Shield Medical Advisory Committee received a letter from Jerry Slaughter, KMS Executive Director.

Upon concluding its hearings, the Committee arrived at a number of recommendations, one of which is that the base of primary care physicians should be broadened.

Warmest wishes for a safe and joyous holiday season are extended to you and yours from the KMS Executive Committee and Staff. Thank you for your support and encouragement this year!

"Kansas Conference on Professional Impairment: Identification, Intervention, Monitoring & Family Involvement" will be held at the Salina Holidome January 17, 1988. Key speakers will include: Eileen Duggan, M.D., Medical Director-PRP, Missouri State Medical Association; Roger Goetz, M.D., and Kay Orr-Goetz, Directors-PRNP, Florida Medical Association; Patricia Green, R.N.-PAP, Kansas State Nurses Association; and Tim Scanlan, M.D., Medical Director-IPP, Kansas Medical Society.

The program will feature:

- * Identification of the Impaired Professional
- * Investigating Allegations of Impairment
- * Intervention: Concepts & Techniques
- * Monitoring the Impaired Professional
- * Family Involvement: Co-Dependency Issues
- * Panel Discussions and Networking Session

Seven hours of CME Cat. 1. For more information, call Laurie Stuewe, R.N., Coordinator of KMS-IPP, at: (913) 235-2383, or (800) 332-0156 (within Kansas).

REGISTRATION FORM:

Complete and return with payment to:

The Kansas Medical Society
1300 Topeka Avenue
Topeka, Kansas 66612

NAME (please print) _____ DEGREE _____

SPOUSE'S NAME (if registering) _____

AFFILIATION _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE _____

Fee Schedule (check applicable fees)

Pre-registration \$45 _____
Registration (after Jan. 6) \$50 _____
Student \$25 _____
Auxiliary/Spouse \$15 _____

(Above costs include materials, break beverages, Sunday continental breakfast, NAB reception.)

Optional dinner at Brookville Hotel (prepayment required) includes dinner/tax/tip.
Cash bar extra.

Number of people X \$10.75 = \$ _____

TOTAL AMOUNT ENCLOSED \$ _____

Check or money order payable to:
KMS Services, Inc.

Pre-registration deadline: Jan. 6.
No refunds after Jan. 15, 1988.

HAPPY
HOLIDAYS

KMS-IPP
CONFERENCE

with such reports and announcements as may come from the House of Delegates or the Council.

4.3 The Society reserves the right to publish in KANSAS MEDICINE any paper read before the Society. The Society also shall be entitled to a copy of the paper if so desired.

4.4 Registration for General and Sectional Meetings. Only the following shall be permitted to register and attend:

4.41 Members: Members of the Society who are in good standing.

4.42 Invited Guests: Non-members of the Society may be invited to the general session or sections, but may be excluded by the Executive Committee of the Society or officers of the Sections.

4.43 Residents and Interns: Residents and interns who are graduates of approved medical or osteopathic schools and who are certified by their hospital.

4.44 Medical Students: Medical students of approved medical and osteopathic schools who are certified by their schools.

4.5 The Scientific Assembly: The Scientific Assembly may be divided into sections representing the various specialties in the practice of medicine. Any member of the Society shall be entitled to attend the scientific programs of specialty sections.

4.51 An application for a new section or a request to discontinue a section shall be referred to the Council for study, whereupon the Council shall make a recommendation to the House of Delegates for final action.

4.52 Sections will be governed by their respective officers.

4.53 Officers will consist of a chairman, vice-chairman and secretary-treasurer.

4.54 Terms of office will be for one (1) year and each officer may succeed himself.

4.55 Each section will prepare its own program subject to approval by the Committee on State Meeting Format. Programs must be submitted to the committee far enough in advance to be included in the annual session program.

4.56 Papers and records of proceedings of the sections shall become the property of the Society and filed in the central office of the Society.

4.57 All resolutions and memorials of a general meeting or a section, intended to be issued in the name of the Society, must be approved by the Council or House of Delegates before being issued or becoming effective.

4.58 Each section may enact its own rules of

conduct that do not conflict with the Constitution or By-Laws of the Society. Sections approved by the Society include:

4.581 Kansas Society of Anesthesiology

4.582 Section on Ophthalmology

4.5822 Hospital Medical Staff Section

Purpose. The purpose of this section is to provide a direct means to address the relationship between members of the Kansas Medical Society and hospital staffs.

Membership. Membership in the section shall be limited to KMS members selected by physician members of the medical staffs of hospitals.

Governing Councils. There shall be a Governing Council of the Hospital Medical Staff Section to direct the programs and activities of the section, subject to the approval of the KMS Council.

Members. There shall be five voting members of the Governing Council, consisting of the officers, delegate and alternate delegate, elected at the business meeting of the section.

Officers. The officers of the section shall have the following duties and responsibilities.

Chairman. The Chairman shall preside at the business meetings of the section and at meetings of the Governing Council.

Vice Chairman. The Vice Chairman shall assist the Chairman and preside in the absence of the Chairman or at his/her request.

Secretary-Treasurer. The Secretary-Treasurer shall maintain such records and accounts as may be necessary or advisable for the conduct of the activities of the section.

Delegate and Alternate Delegate. The Delegate and Alternate Delegate shall represent the members of the section in the KMS House of Delegates.

Term. Governing Council members, including the Delegate and Alternate Delegate, shall serve staggered three-year terms, beginning at the conclusion of the Annual Meeting at which they were elected.

Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next business meeting of the Section.

Business Meeting. There shall be a business meeting of members of the section held prior to each Annual Meeting of the House of Delegates.

Representatives to the Business Meeting. The physician members of the medical staff of each hospital may select a representative to the business meeting of the Hospital Medical Staff Section. The representative must be a KMS member who is an active voting member of the medical staff with clinical privileges at the hospital.

Representatives to the business meeting shall be

elected by and from the active voting members of the medical staff of each hospital.

Representatives to the business meeting shall be properly certified by the President or Secretary of the medical staff.

Only duly selected representatives to the Hospital Medical Staff Section shall have the right to vote at the business meeting of the section, but the meeting shall be open to any member of the Kansas Medical Society. The meeting shall be conducted pursuant to rules or procedure adopted by the Governing Council of the section and approved by the KMS Council.

Purposes of the Business Meeting. The purposes of the business meeting shall be:

- a. To hear such reports as may be appropriate.
- b. To consider and vote upon such matters as may properly come before the meeting.
- c. To adopt resolutions for submission by the section to the House of Delegates of the Kansas Medical Society.
- d. To elect at the business meeting prior to the Annual Meeting of the KMS House of Delegates a Chairman, Vice Chairman, Secretary-Treasurer, Delegate and Alternate Delegate.
- e. To conduct such other business as may properly come before the meeting.

4.583 Kansas Chapter, American Society of Internal Medicine

4.584 Kansas Section, American College of Obstetrics & Gynecology

4.585 Kansas Orthopedic Society

4.586 Kansas Society of Pathologists

4.587 Kansas Chapter, American Academy of Pediatrics

4.588 Kansas Psychiatric Society

4.589 Kansas Chapter, American College of Radiology

4.5810 Kansas Chapter, American College of Surgeons

4.5811 Kansas Chapter, American Academy of Family Physicians

4.5812 Kansas Allergy Society

4.5813 Kansas Urological Society

4.5814 Section, Otolaryngology-Head and Neck Surgery

4.5815 Kansas Dermatological Society

4.5816 Kansas Neurosurgical Society

4.5817 The Kansas Neurological Society

4.5818 Section on Nuclear Medicine

4.5819 Kansas Chapter, American College of Emergency Room Physicians

4.5820 Resident Physicians Section

4.5821 Medical Student Section

5.0 HOUSE OF DELEGATES

5.01 Introduction and General Powers

The House shall consider and advise on matters of interest to the medical profession and of the public in those important matters wherein it is dependent upon the medical profession and shall advocate all proper medical and health legislation, and the diffusion of popular information in relation thereto.

It shall attend to the scientific work and spirit of this Society, and it shall constantly attempt to improve the quality of health care in this state.

The House of Delegates is the ultimate authority in legislative and business affairs of this Society. It may appoint committees from its own members or from members of the Society. Such committees shall report to the House, and may be present and participate in the debates on their reports.

The House may delegate and empower the Council or a special standing committee to employ, advise and supervise an Executive Director whose duties shall be as provided in these By-Laws.

The House shall review the annual budget submitted by the Council and shall make annual appropriations for the expenditures of this Society. It may amend current appropriations at any meeting.

A summary of the proceedings of the House of Delegates shall be published following each annual session in KANSAS MEDICINE.

5.1 Composition

The House of Delegates shall be composed of delegates selected by the component societies, by the elected councilors and in their absence, their alternates, by the recognized sections, the past presidents, and the elected officers of this Society. Members of the Society may attend plenary sessions and others may attend upon invitation of the Speaker.

5.2 Apportionment

5.21 Component Societies: Each component society having made its annual report and paid its assessments as provided in this Constitution and By-Laws shall elect one (1) delegate and one (1) alternate to the House of Delegates for each twenty (20) members and major fraction thereof. Each component single county society shall be entitled to at least one (1) delegate and one (1) alternate, and provided that component multicounty societies have fewer than seventy-five (75) members are entitled to elect one (1) delegate and one (1) alternate, *plus*

one (1) delegate and one (1) alternate for each ten (10) members and major fraction.

Student and resident members shall not be counted for the purposes of determining the number of delegates.

5.22 Organized Specialties: Each organized specialty section recognized by the Society shall be entitled to one (1) delegate and one (1) alternate to be chosen by the section.

5.23 Listing Names: It is the duty of the secretary of each component society and specialty section to send the names of the delegate(s) and alternate(s) to the Executive Director at least sixty (60) days prior to each session.

5.24 Each district councilor shall be a member of the House of Delegates during his Council tenure and in addition to the authorized number of delegates from his component society.

5.3 Delegates

5.31 Qualifications

5.311 Delegates: Each delegate must be a member in good standing of this Society.

5.312 Alternates: An alternate to each delegate shall be elected to substitute for that delegate. Each alternate must be a member in good standing of the Society.

5.313 Substitute Alternate: The House may elect by majority vote a substitute alternate to serve as a delegate for that meeting for a component society which has no delegate or alternate present.

5.314 Proxies: No proxies are recognized.

5.32 Term

5.321 Length: Each delegate and alternate is elected for one (1) year and shall assume office at the first session of the House succeeding his selection.

5.322 Vote: Each delegate is entitled to one (1) vote.

5.33 Registration

All persons attending a session of the House shall register prior to their admission. These registrations are certified by the Committee on Credentials.

5.4 Procedure

5.41 Order of Business

5.411 First Session: The order of business of the first session of the House, unless otherwise ordered by a two-thirds vote of the delegates present, shall be:

5.4111 Registration of delegates, Society members and visitors.

5.4112 Call to order by the Speaker.

5.4113 Announcement of number of delegates

present and registered and the presence of an official quorum.

5.4114 Reading of the minutes of last and any special meeting.

5.4115 The report of the nominating committee is read, after which nominations are made from the floor for the office of President Elect, First Vice President, Second Vice President, Speaker, Vice Speaker, Secretary, Treasurer, AMA Delegate and AMA Alternate Delegate, and a ballot vote where three or more candidates have been nominated for one office so that the election at the second session of the House shall present not more than two (2) candidates for each office.

5.4116 Report of the Constitutional Secretary shall be distributed to all persons in attendance. The Constitutional Secretary shall call attention of the House to any statistics relating to membership that are of exceptional importance.

5.4117 The report of the Treasurer, including a proposed budget for the coming year, shall be distributed to all persons present. The Treasurer shall call attention to any specific financial items that are exceptional. The House shall immediately thereafter act to approve the report of the Treasurer.

5.4118 The report of the Editor of KANSAS MEDICINE shall be prepared and distributed to all persons present.

5.4119 The Speaker of the House of Delegates may invite such persons to present written or oral reports to the House of Delegates which in his judgment will be important for information to the House.

5.41110 The report of the Executive Director shall be prepared and distributed to all persons present.

5.41111 Unfinished business.

5.41112 Reports and presentation of resolutions from Commissions.

5.41113 New business and the introduction of resolutions from component societies, specialty societies, and delegates.

5.41114 Announcements — to include: (1) members of each reference committee; (2) time and place of reference committee meetings; (3) names and districts of expiring councilor and alternate terms; (4) results of primary election; (5) other.

5.41115 Adjournment to reconvene at second meeting.

5.412 Second Session: The official order of business for the second meeting of the House of each annual session shall be:

5.4121 Registration and seating of delegates, Society members and visitors.

5.4122 Call to order by the Speaker.

5.4123 Announcement of number of delegates, the presence of an official quorum.

5.4124 Election of officers (by ballot)

5.4125 Report of reference committees.

5.4126 Unfinished business.

5.4127 New business (this requires consent of a two-thirds majority of delegates present).

5.4128 The Speaker announces the President Elect is now President. The President is invited to present to the House an outline of his plans for the coming year at the time he assumes office. The President then announces the councilors and alternates elected and meeting place of the Council.

5.4129 Installation by the President of the new Speaker and Vice Speaker.

5.41210 Adjournment

5.413 Special Session: The official order of business for a special session of the House shall be:

5.4131 Registration of delegates, Society members and visitors.

5.4132 Call to order by the Speaker.

5.4133 Announcement of number of delegates present and the presence of a quorum.

5.4134 Announcement of business for which session was convened.

5.4135 Report of the commission chairmen and officers pertinent to the subjects for which the special session is convened.

5.4136 Assignment of resolutions to reference committees.

5.4137 Adjournment of the First Session.

5.4138 Second Session — Call to order by the Speaker.

5.4139 Report of the Reference committees.

5.41310 Announcements.

5.41311 Adjournment.

5.42 Privilege of the Floor

The House of Delegates by a two-thirds vote of those present may invite any person to address the House.

5.43 Introduction of Resolutions:

Reports and resolutions for consideration of the House shall be sent to the Executive Office at least six (6) weeks before the date of the annual session. Resolutions or amendments introduced on the floor of the House must be submitted to the Speaker in writing at the time of introduction.

5.44 Process of Resolutions:

5.441 First Session

5.4411 At the first session of the House, all business shall be introduced by title, and referred without debate or action to a reference committee, except as otherwise stipulated in these By-Laws.

5.4412 Resolutions not previously published and distributed to the members of the House shall be read in full.

5.4413 As each resolution is introduced, the Speaker shall designate it with a number.

5.442 Second Session

5.4421 At the second session, the House will receive the report of each reference committee on all business referred to it.

5.44211 If, in the opinion of the reference committee chairman, a resolution can be acted upon without additional discussion, he shall direct the resolution to be placed on the consent calendar. A list of such resolutions shall be presented at the end of the reference committee report. The Speaker shall ask if there is any objection. If an objection appears to any resolution, it shall be removed from the consent calendar and placed before the House for individual consideration. If no objection appears, the resolutions on the consent calendar will be placed as a package before the House for action.

5.4422 Each item of business so reported upon shall be subject to debate and amendment prior to final action.

5.4423 No new business may be considered at the second session of the House except as provided in the By-Laws.

5.4424 If a reference committee fails to submit a report at the second session of the House upon any resolution referred to it, such resolution may be placed before the House by the Speaker and must be so placed upon request of any member.

5.443 Special Session

Resolutions may be considered by the House acting as a whole or by a reference committee prior to action by the House.

5.444 Expiration

Official policies established through resolutions at the House of Delegates shall be in effect for a period of five (5) years, at which time that policy position will be reviewed by the Executive Committee and will expire subject to the approval by the House of Delegates unless superseded or continued by another resolution.

5.45 Quorum

Thirty-five per cent (35%) of constitutionally provided delegates or their respective alternates shall constitute a quorum of the House of Delegates at any regular or special meeting.

5.5 Sessions of the House of Delegates

5.51 Location: The time and place shall be determined by the Council. Notice of annual meetings shall be sent to each component society prior to January 1 of the year the meeting is to be held and shall state the time and place of the meeting.

5.52 Invitation From Component Societies: The Council shall, not later than October, consider invitations received from component societies to serve as host to the annual session for the fifth year following and shall select the meeting place and the date. Should invitations not be received, the Council shall select a meeting place.

5.53 Regular: The House of Delegates shall conduct two meetings, separated by at least twenty-four (24) hours, during each annual session. These may be adjourned and reconvened as necessary.

5.54 Special: Special sessions shall be called by the Speaker as requested by the President upon approval of the Council or the Executive Committee. Special sessions shall be called by the Speaker upon the written request of twenty-five per cent (25%) of the delegates from component societies. When a special meeting is called, the Executive Director shall notify each component society at least twenty (20) days before the meeting date. The notice shall specify the time and place of meeting and the purpose for which it is called.

5.6 Meetings

5.61 Plenary: The House may conduct a meeting to which any person may be admitted. By majority vote of the delegates present, a plenary meeting may become a closed or executive meeting.

5.62 Closed: A closed meeting is restricted to members of this Society and to members of the staff.

5.63 Executive: An executive meeting is limited to delegates and to such employees of this Society necessary for the functioning of the House.

5.7 Designation

The Credentials Committee and the Reference Committee are regularly appointed committees of the House of Delegates.

5.8 Membership

5.81 The Credentials Committee shall consist of three (3) members from separate Council districts appointed by the Speaker for a term of one (1) session. The Speaker shall designate the chairman.

5.82 Each Reference Committee shall consist of not less than three (3) nor more than seven (7) members of the House appointed by the Speaker. The Speaker shall designate the chairman.

5.9 Duties

5.91 Credentials Committee

5.911 The Credentials Committee shall examine the credentials of all who seek admission to the House, and rule on the seating of all delegates. Any member of the Society registered for the annual meeting may be admitted to the visitors' section.

5.912 An individual whose credentials are questioned may appeal to the House immediately following the report of the Credentials Committee that a quorum exists and the issue may be decided at that time.

5.913 The Speaker shall appoint a Sergeant-at-Arms.

5.914 The Credentials Committee shall report to the House upon request of the Speaker on:

5.9141 Total number of members of the House eligible to vote.

5.9142 Number of members registered and seated.

5.9143 Announcement of quorum.

5.92 Reference Committees

5.921 The Reference Committees are appointed for a session of House to consider resolutions referred to them.

5.922 The duties of the Reference Committees shall be:

5.9221 To hold open hearings on all referred resolutions at a time and place announced at the first session of the House.

5.9222 To deliberate in closed session on each resolution, and after consideration recommend its final disposition.

5.923 A member of a reference committee who wishes to make a minority report must refrain from signing the majority report and must make his intentions known to the other members of the reference committee while it is in closed session and prior to the presentation of the majority report to the House.

5.93 Other Committees

The Speaker may appoint such other committees as are needed.

6.0 ELECTED OFFICERS

6.1 Designations

The elected officers of the Society are those specified in Article VI of the Constitution. No member shall hold two elected offices in this Society at one time excepting delegates and alternate delegates to the American Medical Association, who may be elected and serve during a concomitant tenure in another elective office of this Society.

6.2 Qualifications

An elected officer must have been for at least two (2) years immediately prior to his election, an active member of the Kansas Medical Society. The Speaker and Vice Speaker of the House shall be elected from among the members of the House.

6.3 Terms

6.31 President Elect

The President Elect shall be elected annually. He shall serve until the next inaugural after his election when he becomes President.

6.32 First Vice President, Second Vice President, Speaker, Vice Speaker, Secretary and Treasurer.

The First Vice President, Second Vice President, Speaker, Vice Speaker, Secretary and Treasurer shall be elected annually, each to serve for one (1) year or until a successor is elected and installed.

6.33 AMA Delegates

Delegates to the House of Delegates of the American Medical Association shall be elected for two-year terms of office. The term of the delegate-elect shall begin January 1 of the year succeeding election.

6.331 AMA Alternate Delegates

There shall be one alternate delegate for each delegate. The President shall serve as one alternate delegate. One of the alternate delegates shall be appointed by the President subject to Executive Committee approval, to serve a term of one year, beginning January 1. The remaining alternate delegates shall be elected at the annual meeting to two-year terms of office, beginning January 1 of the year succeeding election.

6.4 Presidential Succession

If the Presidency is vacated by reason of death, disability for the unexpired term, resignation, or impeachment and conviction, the line of succession shall be the President Elect, the First Vice President, the Second Vice President, the Speaker and the Vice Speaker.

6.41 If the disability of a president is contested, it shall be determined by a two-thirds concurrence of the Council.

6.5 Interim Vacancies

Should vacancies occur in the office of Secretary or Treasurer, the Council shall fill these positions as provided in the By-Laws.

6.6 Nominations

The Council shall annually at the conclusion of the annual session select three (3) physicians who are members of this Society, each representing a different council district other than the districts of

the two (2) recent living past presidents to comprise the nominating committee. The Council shall name a chairman. The committee shall meet not later than ninety (90) days prior to the next annual session and present for publication in *KANSAS MEDICINE* a list of candidates for each elective office consisting of one or more candidates for the offices of President Elect, First Vice President, Secretary, Treasurer, Speaker of the House of Delegates, Vice Speaker of the House of Delegates, one (1) or more candidates for the office of delegate-elect and alternate delegate-elect to the American Medical Association, and three (3) or more candidates for the office of Second Vice President. The candidates for Treasurer should be named from residents of the vicinity of the central office whenever possible.

6.7 Elections

6.71 Time: The election of officers shall be held at the last meeting of the House of Delegates at each annual session. During the first session nominations for each office are made. When more than two (2) candidates are nominated for any office, a primary election shall be held at the first House of Delegates meeting. The name receiving the fewest votes shall be eliminated and balloting shall continue until not more than two (2) remain. Tellers shall announce in alphabetical order the names of the two who receive the largest number of votes for each office. In case there exists a tie for second place, another ballot shall be held to select a second candidate. At the last House of Delegates meeting each authorized delegate shall cast his ballot at the time he registers to attend the meeting, and this will constitute the election. In case of a tie, the Speaker, who does not vote otherwise, shall cast the deciding vote.

6.72 Method: All elections of officers shall be by ballot.

6.8 Installation of the Elected Officers

Elected officers, except delegates and alternate delegates to the American Medical Association House of Delegates, shall be installed prior to adjournment of the House at the annual session and shall begin their term of office at the conclusion of the annual session.

6.9 Installation of the President

The oath of office shall be administered to the President Elect during the President's Banquet and/or reception at the annual session. The President Elect shall become President at the conclusion of the business of the House at the annual session.

6.10 Officials Impeached

Officials impeached by the Council are tried by the House of Delegates. A two-thirds vote is necessary for conviction.

7.0 DUTIES OF OFFICERS

7.1 President

The President is the chief executive officer and principal spokesman of the Society. He shall counsel with officers, and others, toward the best interests of the public and this Society, to attempt to further the aims and activities of this Society to the fullest extent. He shall perform such services as custom, necessity and parliamentary procedure require. He shall in accordance with these By-Laws announce his appointments to commissions. He shall be an ex-officio member of all committees and commissions. He shall be extended an opportunity to preside at all major functions of the annual session and shall deliver an address at the time arranged by the Committee on Arrangements. He shall be encouraged to visit the various Council districts during his term of office.

7.2 President Elect

The President Elect shall familiarize himself with the personnel and work of the various committees and of this Society in general. He shall be ready to counsel with the President on matters affecting the future of this Society, and shall otherwise prepare himself for assuming the leadership of this Society at the proper time. Except as is otherwise provided in the By-Laws, he shall appoint a chairman and other members of each commission, and other temporary committees, to serve during his term as President. The complete list of appointments to commissions shall be available for publication and distribution to the membership when he assumes the office of President. The President Elect shall assume the Presidency in the event of the death of the President or the inability of the President to perform the duties of the office. In the event of such succession to office, the President Elect shall not be disqualified from serving his term as President for which he was duly elected.

7.3 First Vice President

The First Vice President shall assist the President in the performance of his duties, shall preside in his absence at the meetings of this Society, or the Council, and shall represent the President in his absence.

7.4 Second Vice President

The Second Vice President shall also assist the President in the performance of his duties.

7.5 Speaker

The House of Delegates shall annually elect from its membership a Speaker and a Vice Speaker whose terms of office begin upon adjournment of the last session of the House and continue through adjourn-

ment of the last session at the next annual session. They are eligible for succession.

The Speaker is the presiding officer over all sessions of the House. It is his duty, upon consultation with the Vice Speaker, to appoint reference committees. He shall refer resolutions to reference committees and shall aid delegates and committees to the extent of his ability toward the end that all business of the House may be conducted in an efficient manner.

7.6 Vice Speaker

In the absence of the Speaker or at his pleasure, the Vice Speaker will preside over the House and will perform such duties as would otherwise be performed by the Speaker.

At the first session of the House, nominations shall be placed for the office of Speaker and for the office of Vice Speaker. In the event there are more than two (2) nominations for either office, a primary ballot shall be taken and the names of the two (2) receiving the largest number of votes will appear on the ballot at the last session of the House where the election shall take place.

7.7 Secretary

The Secretary shall advise the Executive Director in all secretarial matters of this Society and shall act as the corporate secretary for the executive of official documents. He shall perform such duties as are placed upon him by this Constitution and By-Laws, and in the event of death, resignation or removal of the Executive Director, shall assume the duties of that office until the vacancy is filled.

7.8 Treasurer

The Treasurer shall be the custodian of all moneys, securities and valuable papers of this Society. He shall deposit them in safe banking institutions, or invest them, subject to the direction of the Council. He shall be bonded at the expense of this Society in such amount as the House may require. He shall pay all authorized obligations of this Society by vouchers. He may authorize the Executive Director to pay authorized obligations on his behalf. He shall keep a detailed account of all receipts and disbursements, and shall make an annual report to the House concerning the financial transactions of this Society for the preceding fiscal year, the funds of this Society in his care and his actions as Treasurer. He shall subject his accounts to such examinations as this House or the Council may order. He shall establish a revolving fund in an amount approved by the Council for routine expenses of the Executive office, which fund shall be set aside in a separate banking institution and be subject to check by the Executive Director with the understanding that dis-

bursments therefrom shall be satisfactorily accounted by the Executive Director to the Treasurer before replenishment is made.

7.9 Executive Director

The Executive Director shall perform the duties usual to such office except those specifically imposed by this Constitution and By-Laws upon the officers, councilors, committees, commissions, and other representatives of this Society.

He shall be under the employ of the Council, or its representative committee, and in case of his death, resignation or removal, the Council, or its representative committee, shall have the power to fill the vacancy. He shall employ such assistants as the House, the Council, or their representative committees may direct.

The amount of his salary shall be fixed by the Council or its representative committee, with approval of the House of Delegates. He shall be allowed traveling expenses to the extent approved by the Council. He shall use the revolving fund with due regard for efficiency and good business judgment in furtherance of the work entrusted to his care.

He shall be bonded at the expense of this Society in such amount as the Council may require.

He shall:

7.91 Account for, and promptly turn over to the Treasurer all funds of this Society which come into his hands.

7.92 Receive all bills against this Society.

7.93 Investigate their fairness and correctness.

7.94 Prepare vouchers covering the same.

7.95 Forward them, together with proper payment, to the Treasurer, for payment as provided in these By-Laws; or pay them with prior authorization from the Treasurer.

7.96 Keep an account with the component societies of the amount of their assessments, collect the same and promptly turn over the proceeds to the Treasurer.

7.97 Make an annual report of his activities to the House, and shall make such reports as the Council, or its authorized committees may require.

7.98 Within thirty (30) days preceding each annual session, submit his financial books and records to a certified accountant approved by the Council, whose report thereon shall accompany his annual report.

7.99 With the advice of all interested officers, prepare and submit annually to the House a tentative budget of this Society for the ensuing fiscal year,

together with the recommendations of the Council, or its authorized finance committee, thereon.

7.910 Subject to instruction by the House, the Council, or the President, he shall act as general administrative officer and business manager of this Society. He shall refer to the proper officials all administrative questions as properly come within their jurisdiction.

7.911 Attend the annual sessions, the meetings of the House, the Council, as many of the committee meetings as possible, and shall keep the minutes of their proceedings.

7.912 Undertake secretarial functions for all officers, councilors, committees and commissions of this Society, and shall assist wherever possible in the performance of their duties.

7.913 With the cooperation of the secretaries of the component societies, he shall keep a record of all legally licensed doctors of medicine in this state, together with such information as is available about each. He shall transmit to the American Medical Association all copies of records that may be desired by that association, together with such other information as may be of value.

7.914 Endeavor to visit component societies when his duties will permit, or when an emergency requires personal attention, and shall keep the officers of the component societies informed about the activities of this Society and of the medical profession in general by the issuance of bulletins.

7.915 Supply the component societies with necessary forms and blanks for conducting their official business with this Society.

7.916 Inform the Society upon all pending or enacted legislation and upon activities of governmental offices and agencies affecting the medical profession and public health.

7.917 Secure, upon invitation, medical speakers to address lay organizations on subjects which are in accord with the aims and ideals of this Society. When requested, he shall assist the component societies in securing speakers and in preparing programs.

7.918 Notify all members of meetings, officers of their election, and committees of their appointment and duties.

7.919 Upon authorization by the Committee on Arrangements, he shall prepare and issue an official program for each annual session.

7.920 Provide for the registration of members and delegates at each annual session.

7.921 Be the custodian of the general papers and

records of this Society except as properly belong in the custody of other officials.

7.922 Conduct the official correspondence of this Society, and shall sign all authorized communications.

7.923 Aid the councilors in organizing and improving the component and district societies, and in the extension of the usefulness and influence of this Society.

7.924 Act as business manager of KANSAS MEDICINE under supervision of the Editorial Board, and in a similar capacity to the extent authorized for other publications of this Society.

7.925 Perform any additional duties as may be required by the House, the Council, their committees or the President.

8.0 THE COUNCIL

8.1 Composition

8.11 Members of the Council are the President, President Elect, First Vice President, Second Vice President, Secretary, Treasurer, and Speaker and Vice Speaker of the House, Delegates and Alternate Delegates to the American Medical Association, and a councilor from each Council District. Each councilor and an alternate are to be elected by members of the component societies of the district prior to the convening of the House of Delegates; excepted, that the councilor or his alternate may be elected by a caucus of the delegates if the members have not done so by the date the House of Delegates convenes. The elected alternate replaces an active member in his absence.

8.12 Associate membership of the Council includes alternate councilors and one (1) representative each from the University of Kansas School of Medicine, the Kansas State Board of Health, the Kansas State Board of Healing Arts, and one (1) representative each from recognized specialty organizations. Associate members may attend plenary sessions of the Council but shall not be entitled to vote.

8.13 The Executive Director of the Society attends all sessions of the Council as an administrative advisor.

8.14 Advisory members of the Council are the Editor of KANSAS MEDICINE, chairmen of the Society commissions, and past presidents. They may attend plenary sessions of the Council, but are not entitled to vote.

8.15 The Executive Committee of the Council shall be composed of the President, the President Elect, the Immediate Past President, the First Vice

President, the Second Vice President, the Secretary, the Treasurer, the Delegates to the AMA, the Speaker and Vice Speaker of the House of Delegates. The President of the Kansas Foundation for Medical Care shall be an ex-officio, non-voting member. The committee shall meet regularly and at least six (6) times during each year at the call of the President, and shall have authority to act in the interim between meetings of the Council upon all matters which would ordinarily require approval by the Council, which do not properly necessitate a special meeting of the Council and which have not been delegated elsewhere by these By-Laws.

8.2 Meetings

8.21 The Council meets at the conclusion of each annual session of the House of Delegates and at the call of the President during the year. A meeting is convened upon petition of five (5) active members of the Council.

8.22 Business may be transacted when a quorum is present. A majority of the active members is a quorum.

8.23 Adequate notice must be given the members by the Executive Director of the time and place of the meeting.

8.3 Duties

8.31 Between annual or special sessions of the House of Delegates, the Council or the Executive Committee of the Council will transact business on behalf of the Society. Council or Executive Committee action may not conflict with former action of the House of Delegates. Transactions of the Council otherwise have the same authority as those of the House of Delegates except they cannot bind the Society beyond its next annual session.

8.32 The Council is authorized to issue or revoke charters to component societies in the name of the Society. The council for the district of origin presents the application for charter to the Council. The application must contain the following information:

8.321 The geographical area to be included in the proposed component society.

8.322 Certification by the presiding officer of each component society within the area of the new society that his members have voted to relinquish the charter in effect.

8.323 A guarantee that all members affected will retain initial membership in the new society, but be subject to its by-laws subsequently.

8.324 The name of the new society; all to be attested by the signatures of the elected officers.

8.33 The Council shall supervise the publication

of KANSAS MEDICINE. It appoints an editorial board of five (5) members, one of whom is named Editor (See 10.0).

8.34 The Council is responsible for the funds and expenditures of the Society. The Treasurer submits to it a budget of estimated expenses for the coming year. Appropriation of money for special purposes not previously budgeted must be authorized by the Council.

8.35 The Council sets the amount of dues for the coming year, directing the Executive Director to inform component societies no later than October 31.

8.36 The Council may impeach elected officers and councilors.

8.37 The Council is responsible for the determination, five (5) years in advance, of the time and place of the annual session of the Society.

8.38 The Council employs and supervises the activities of the Executive Director.

8.39 The President of the Society presides over the Council. In his absence the First Vice President will preside.

8.310 The Council may create committees from its membership to act between Council meetings. Special committees may include additional members of the Society who are not Council members. When the Society is invited to send a representative, or committee for service outside its own jurisdiction, the appointment(s) is made by the Council except in emergency when the Executive Committee may appoint.

8.311 All money of the Society is paid to the Treasurer who is accountable for it. The Council may inspect or audit the accounts of the Treasurer at any time, but at least annually; it may review or audit the expenditure of any officer, board or committee, and insure annual reports to the House of Delegates on all expenditures of the Society.

8.312 If the office of Secretary or Treasurer is vacated, the Council appoints a successor for the unexpired term. To protect the new Treasurer, an audit is conducted at once. If a councilor position is vacated, the corresponding alternate sits as councilor until the annual session. Then a councilor is elected as provided above to complete the three (3) year term. The alternate so seated becomes a voting member of the Council. If the incomplete term is for less than two (2) years, the elected councilor is eligible for two (2) more terms.

8.313 A summary of Council activities and reports to it between sessions of the House of Dele-

gates is submitted to the House at each annual meeting.

8.4 Council Districts

Council Districts are comprised as follows:

8.41 District #1: Atchison, Brown, Doniphan, Jackson, Jefferson, Leavenworth, Marshall, Nemaha, and Washington Counties.

8.42 District #2: Wyandotte County.

8.43 District #3: Johnson County.

8.44 District #4: Allen, Bourbon, Cherokee, Crawford, Labette, Montgomery, Neosho, Wilson and Woodson Counties.

8.45 District #5: Clay, Geary, Pottawatomie, and Riley Counties.

8.46 District #6: Shawnee County.

8.47 District #7: Chase, Coffey, Lyon, Morris, Osage and Wabaunsee Counties.

8.48 District #8: Butler, Cowley and Greenwood Counties.

8.49 District #9: Cloud, Dickinson, Jewell, Mitchell, Ottawa, Republic and Saline Counties.

8.410 District #10: Harvey, McPherson, Marion, Reno and Rice Counties.

8.411 District #11: Sedgwick County.

8.412 District #12: Barber, Harper, Kingman, Pratt and Sumner Counties.

8.413 District #13: Ellis, Ellsworth, Graham, Lincoln, Ness, Osborne, Phillips, Rooks, Rush, Russell, Smith and Trego Counties.

8.414 District #14: Barton, Pawnee and Stafford Counties.

8.415 District #15: Clark, Comanche, Edwards, Ford, Gray, Hodgeman, Kiowa, Meade and Seward Counties.

8.416 District #16: Cheyenne, Decatur, Gove, Logan, Norton, Rawlins, Sheridan, Sherman, Thomas and Wallace Counties.

8.417 District #17: Finney, Grant, Greeley, Hamilton, Haskell, Kearney, Lane, Morton, Scott, Stanton, Stevens and Wichita Counties.

8.418 District #18: Anderson, Douglas, Franklin, Linn and Miami Counties.

8.419 District #19: Allen, Chautauqua, Elk, Montgomery, Neosho, Wilson and Woodson Counties.

8.5 Notification of Councilor Election

The Executive Director will notify all component societies in a given Council district three (3) months prior to the annual session at which its councilor term ends. A poll may be held in the district before

the annual session to select the new councilor whose official election is held as provided above.

8.6 Councilor Term of Office

Each councilor is elected for three (3) years. He may serve two (2) successive terms except as limited above (8.313). On one year, terms begin for councilors in Districts 1, 3, 5, 8, 9 and 17; the next year in Districts 2, 4, 11, 13, 14, 15 and 19; the third year in Districts 6, 7, 10, 12, 16 and 18.

8.7 Duties of the Councilor

The councilor represents the members of his district in the government of the Society. He is expected to know their needs and represent them fairly. Conversely, he represents the Society to the members of his district, giving rise to some of these duties by which he is bound but not limited:

8.71 He must afford societies within his district complete understanding of Society policy and activities.

8.72 He must visit each component society in his district at least once annually.

8.73 He must function as censor and peacemaker in his district.

8.74 He must aid in improving the organization of the societies in his district for their own efficiency and to augment the proper function of this Society.

8.75 He will call a district meeting at the request of the President.

8.76 He is expected to attend meetings of the Council. If he cannot be present, he must notify his alternate who will sit in the Council for him and exercise the vote of his district. His failure to notify his alternate after two (2) consecutive absences will represent resignation and the component societies in the district will select his successor to fill the unexpired term of his appointment.

8.77 He is obliged to teach his alternate the duties of councilor, to acquaint the alternate with Council policies and procedures, and to keep him informed of current Society transactions.

8.78 He serves as a voting member of the House of Delegates during his Council tenure (See 5.24).

8.79 He/she will serve as a member of the KMS Impaired Physician Committee during his/her Council tenure.

9.0 COMMITTEES AND COMMISSIONS

Commissions and Committees are appointed by the President for a one-year term. The Chairman, size and membership of such commissions and committees shall be designated by the President. Commissions and Committees may introduce resolutions

for consideration by the House of Delegates.

9.1 Professional Practices Review Committee

There shall be a Professional Practices Review Committee representing different specialties. One member of the committee shall be a physician representing the Kansas State Board of Healing Arts. The President shall appoint the committee subject to approval by the Council. The majority of the Professional Practices Review Committee shall constitute a quorum and the affirmative vote of a majority of those members present shall constitute the action of the Professional Practices Review Committee.

9.11 The Committee shall invite as a temporary, ex-officio member the councilor from whose district a complaint or possible cause of action shall have been submitted. In the event that the councilor is the subject of the complaint or cause of action, the alternate councilor shall sit in his place.

9.12 In the event that any member of the Committee is the subject of the complaint or cause of action, he shall be excluded during the Committee's deliberations and action on such complaint and from Committee membership, but shall otherwise retain the same rights and privileges as any other member of this Society.

9.13 The Professional Practices Review Committee is charged with the responsibility of reviewing and acting on grievances or matters of ethics involving a member of this Society. The committee will conduct such inquiries and investigations as are needed to render timely decisions on matters referred to it. Decisions of the committee may be appealed to the Council. The decision of the Council on such appeals is final and subject to no higher appeal within this Society. The committee may utilize such consultants and advisory committees as it may require.

9.14 The Professional Practices Review Committee shall receive written complaints from any person, whether or not he or she is a physician, a member of this Society, a patient of a physician, or any other person, lay or professional.

9.15 After investigation of, impartial hearing of, and deliberation upon a complaint, the Professional Practices Review Committee by majority vote, may:

9.151 Consider the case closed.

9.152 Recommend settlement.

9.153 Express its advice to a member of this Society on any matter pertaining to his or her professional conduct.

9.154 Recommend to the Council of the Society:

9.1541 That it take action to expel, suspend or reprimand a member.

9.1542 Submit proposed charges to an appropriate state or federal law enforcement agency.

9.1543 Submit the case and findings to the Kansas State Board of Healing Arts.

9.16 Upon reaching a decision, the Professional Practices Review Committee chairman shall transmit to the Council and the Board of Healing Arts a written statement and explanation of the final decision as soon as possible after the committee has completed the investigation of the case and has arrived at its decision.

9.17 The Professional Practices Review Committee shall keep a complete record of all complaints, answers, findings and final disposition of its decisions and disposal of complaints, and shall prepare an annual report to the Kansas Medical Society.

9.18 The Professional Practices Review Committee shall not at any time exceed or take by assumption any authority other than that granted by this Constitution and By-Laws.

9.2 Committee on State Meeting Format

The Committee on State Meeting Format is comprised of the most recent general chairman of the annual session from each city where sessions are held. The term of office ends when a new general chairman is appointed by the respective component society. The President Elect is chairman of this committee which meets not later than sixty (60) days after each annual session in the host city for the next session. The meeting is held to review with the local planning committee plans for the coming session. The committee further recommends a general meeting plan to the host society selected for two (2) years later.

9.3 Policy Statements

Public statements of policy by commissions or committees have only the force of recommendations, becoming Society policy after approval of the House of Delegates or the Council.

9.4 Expenditures

Expenditures by commissions or committees must have prior approval of the House of Delegates or the Council to be binding on the Society. No contract or monetary obligation shall be incurred in the name of the Kansas Medical Society by any member, employee or agent until he is authorized by the House of Delegates, the Council or the Executive Committee. Authorization cannot extend beyond the next annual session.

10.0 THE EDITORIAL BOARD

10.1 Composition and Appointment

The Editorial Board is comprised of the society members, appointed by the Council. When a vacancy occurs it is to be filled for the unexpired term at the next meeting of the Council.

10.2 Duties of the Chairman

10.21 To direct the operation of the Board and be the Editor of KANSAS MEDICINE.

10.22 To make reports to the House and Council of the activities of the Board.

10.3 Duties of the Board

10.31 To perform the functions necessary to the publication of KANSAS MEDICINE and other publications as considered necessary by the House of Delegates or the Council.

10.32 The Board may appoint associate editors from any Council district for particular functions in fulfillment of its duties.

10.33 The Board with its associate editors shall meet at the call of the chairman.

10.4 Financial Regulations

10.41 The Board is enjoined to maintain KANSAS MEDICINE within budgetary limits established by the Council.

10.42 Expenditures authorized by the Board are to be paid by the Kansas Medical Society upon authorization by the Business Manager of KANSAS MEDICINE.

11.0 COMPONENT SOCIETIES

11.1 Definition

Component societies are groups of physicians organized in the State of Kansas, adopting principles of organization in accordance with these By-Laws and receiving a charter from this Society.

11.2 Charter Requirements

11.21 Each county shall be included among the component societies in this state, but only one (1) component society may be chartered in a county.

11.22 New component societies will not be chartered with fewer than ten (10) members.

11.23 Physicians in counties with too few physicians for a successful organization may affiliate with those of adjoining counties to form a multi-county component society.

11.24 Charters are granted to component societies upon action of the Council as provided above (8.32).

11.25 Following Council recommendation, the House of Delegates may revoke the charter of a

component society whose actions conflict with these By-Laws.

11.26 If the active membership of a component society falls below four (4) in number, its charter shall be revoked and the members reassigned by the Council to one of the following alternatives:

11.261 Attach the entire membership to the nearest component society.

11.262 Attach the entire membership to any adjacent medical society by unanimous request of the members.

11.263 Attach the members separately to adjacent medical societies for reasonable cause.

11.3 General Regulations

Component societies may set rules for membership qualification, organization and transaction of business except as specifically limited in these By-Laws.

11.4 Regulations For Membership

11.41 Since membership in this Society is dependent on that of the component society except as noted in Section 11.411, any reputable and ethical physician with the degree of Doctor of Medicine or Osteopathy, or their equivalent, from an accredited medical or osteopathic school, fully licensed to practice medicine and surgery by the Kansas State Board of Healing Arts, and the majority of his professional work being conducted in the state, shall have the privilege of applying for component society membership. Also eligible for membership shall be students attending accredited medical schools in Kansas.

11.411 Medical students and resident physicians shall be eligible for membership in the Kansas Medical Society by applying through the component medical society or by applying directly to the Student or Resident Physician Section.

11.42 A physician may not hold active membership in two component societies.

11.43 No physician may be an active member of a component society without becoming a member of the Kansas Medical Society and the American Medical Association.

11.44 A physician living in one county but conducting his practice in another is eligible for membership in the county where the majority of his work is performed. He may maintain active membership for reason of convenience in the county of his residence only with the permission of the society within whose jurisdiction he practices.

11.5 Movement Within the State

A member of any component society, upon es-

tablishing the majority of his practice in the area of another component society, may retain his original membership only with the permission of the society into whose jurisdiction he moves.

11.6 Transfer of Membership

A member desiring to transfer membership from one component society to another applies to the new society in the same manner as an original applicant. His application is accompanied with an appropriate recommendation and a report of his standing in the previous society, attested by the president. When the application has been acted upon, the secretary will notify the applicant at once of the society's decision. The secretary of the previous society is also notified since acceptance by the new society requires that he be dropped from the roll of previous membership. Rejection by the new society does not affect membership status in the previous society.

11.7 The Annual Report

The secretary of each component society will maintain a roster of its membership and of non-affiliated registered doctors of medicine or osteopathy within its boundaries. The roster must include for each member his address, medical or osteopathic school and date of graduation, date of license to practice in Kansas, and the dates of past changes in membership status. Only the names and addresses of non-members need be recorded.

On or before the first day of February, the secretary shall forward a current roster to the Executive Office, including notations of death or change of membership status among members and, as far as possible, among non-members.

11.8 Dues and Assessments

11.81 All dues owed the Society should be remitted before the first of February of each year unless permission for a delay is secured from the President. The remittance may not be delayed beyond the first of April of the same year. The number of delegates of all component societies shall be determined on the basis of information regarding membership available to the state society office as of December 31 of the prior year; and a list of delegates and alternates shall be submitted to the Executive Director no later than March 20 of each year for the purpose of publishing the names in the program of the annual meeting in May. Assessments are due under the same rule unless special provisions are set by the Council.

11.811 A member delinquent in the payment of his dues on April 1 of that dues-paying year shall be suspended.

11.8111 A member remaining in arrears as of

June 1 of that dues paying year shall be removed from the membership rolls.

11.82 Individual checks of funds for dues to the American Medical Association are transmitted from the treasurer of the component society through the Executive Office to the proper destination.

11.83 A component society failing to pay its dues or assessments according to these By-Laws is suspended from membership in the Society until the requirements are met or until written certification of the suspension of members in arrears is received by the Executive Office.

11.831 Any member dropped from the membership rolls for delinquent dues shall be readmitted only after applying as a new member.

11.84 A component society suspended from membership in violation of this section is not eligible collectively or individually to participate in the proceedings of this Society nor seats in the House of Delegates until the deficiency has been corrected.

11.85 Punitive action will not be instituted against a component society certifying that members in arrears have sufficient cause from illness, leave of absence, or otherwise, which prevents the practice of their profession. If the component society finds cause to waive the local dues of a delinquent member, a written account should be sent to the Executive Office. The Council will then determine whether the waiver should be properly extended to the dues of the Society. The secretary of the concerned component society will be notified of the Council decision by its district councilor.

12.0 RULES OF ORDER

Deliberations of this Society and its subsidiary Council, sections, commissions and committees shall be governed by these By-Laws, and when not otherwise specified by the provisions of Sturges' Standard Code of Parliamentary Procedure.

"The Rules of Order and By-Laws of this Society

may be suspended at any time by a vote of two-thirds of those delegates present."

13.0 OFFICIAL STATEMENTS

Memorials, resolutions or opinions of any character which conflict with policies of the House of Delegates shall not be issued in the name of the Kansas Medical Society. No obligation, oral or written, shall be incurred in the name of the Kansas Medical Society by any member, employee or agent unless the same has been previously authorized by vote of the House of Delegates, or the Council, or the Executive Committee and no such authority shall be extended beyond the next annual meeting of the House of Delegates.

14.0 MEDICAL ETHICS

The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members.

15.0 AMENDMENTS

These By-Laws may be amended by a two-thirds majority of the House of Delegates present provided such amendment has been considered by a reference committee.

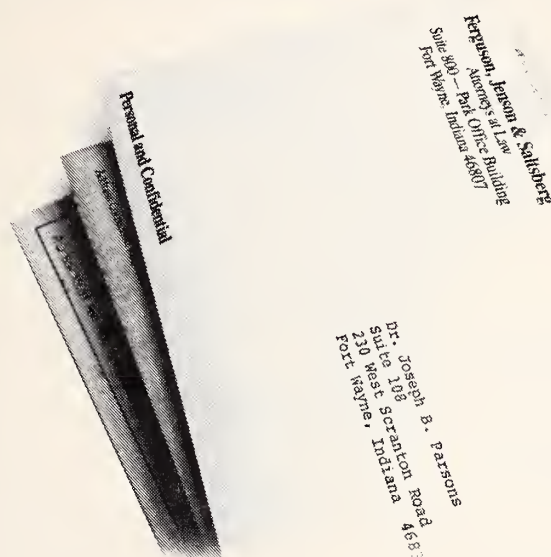
RESOLUTION OF ADOPTION

Be it hereby resolved that this revised Constitution and By-Laws shall be in full force and effect at the close of the meeting of its adoption and shall supersede all prior Constitutions, By-Laws and Amendments.

Likewise, officers, councilors, board and committee members holding offices for definite terms under the previous Constitution and By-Laws shall serve until expiration of term for which elected and until their successors, as provided by this revised Constitution and By-Laws, are duly elected, qualified and installed.



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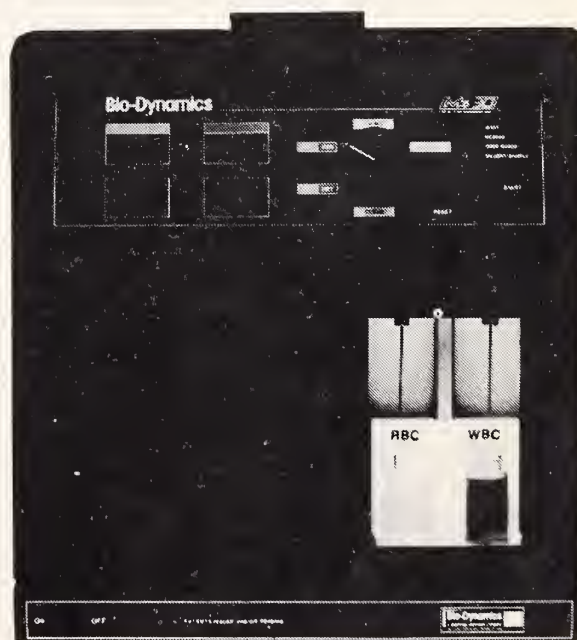
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INDEX TO VOLUME 88

JANUARY 1987 TO DECEMBER 1987 INCLUSIVE

AUTHORS

Abdou, Nabih I.	85
Aggarwal, J. M.	78
Ahmed, I.	121
Ammar, Alex D.	154
Barnes, Mary L.	119
Beach, Robert	113
Becker, Nancy	85
Bernhardt, M.	267
Bloom, Barry T.	314
Bouda, David W.	159
Brown, M.	193
Chaudhary, M. Asghar	116
Cuppige, Francis E.	196
Emami, Abbas	317
Francisco, W. David	223
Friesen, Doug	84
Goering, Donald D.	27
Goldberg, Herbert R.	162
Goodpasture, Hewitt C.	227
Govaker, David A.	291
Gray, David E.	21, 142
Halley, M. Martin	261, 294
Hassanein, Ruth	196
Hayes, William	195
Jones, Randy F.	187
Khan, Rubina	227
King, Charles R.	113
Kuhns, Henry R.	227
Lawton, Steven Keith	150
Leitch, David M.	33
Liese, Bruce S.	155, 291
<i>Loss Prevention Letter</i>	265
Marsh, H. O.	267
Meyer, Warren E.	289
Morgan, Jon A.	227
Neiburger, James B.	46, 78
Neuenschwander, John Rand	98
Openshaw, Calvin R.	110
Patel, Kirit S.	46
Pearce, Eugene W. J.	324
Peterie, Jerry D.	227
Plaster, R. L.	267
Price, James G.	155
Razek, Zack A.	195
Reals, William J.	66
Robinson, R. H.	84
Saving, Kay L.	119
Stratton, Wayne T.	25, 50, 90, 127, 166, 201, 232, 273, 298, 320, 340
Suenaga, Ronsuke	85
Tinterow, Maurice M.	190
Trueworthy, Robert C.	317
Vats, Tribhawan S.	119, 317

Walsh, David J.	81
Wortman, Jack A.	187
Wright, Kevin	326
Wrona, Marcia	196
Ziegler, John M.	43
Zuckerman, Mortimer B.	301

INDEX TO SUBJECT MATTER

AIDS:	
Male Contraception and AIDS Prevention: The Need for Involvement by Kansas Physicians	193
Allergy & Immunology:	
Asthma Complicated by Sinusitis	46
Evaluation of Clinical Immunologic Tests	85
Penicillin Allergy Update	78
Post-Splenectomy Sepsis	119
AMA:	
Initiative on Adolescent Health	72
Anesthesiology:	
Total Spinal Anesthesia — A Complication of Inter- costal Nerve Block	84
Blood and Lymphatics System:	
Idiopathic Thrombocytopenic Purpura in Children ...	317
Cardiology & Cardiovascular Diseases:	
Aggressive Early Management of Postinfarction Myo- cardial Rupture	195
Cardiac Resuscitation in Rural Kansas	187
Mortality of Elective Abdominal Aortic Surgery in Oc- togenarians	154
Cardiovascular System:	
Aggressive Early Management of Postinfarction Myo- cardial Rupture	195
Cardiac Resuscitation in Rural Kansas	187
Mortality of Elective Abdominal Aortic Surgery in Oc- togenarians	154
Current Comment:	
Evaluation of Clinical Immunologic Tests	85
Family Practice:	
Evaluation of Clinical Immunologic Tests	85
Graduate Followup of UKSM-KC Family Practice Res- idency Training	155
Gastroenterology:	
Foreign Bodies in the Upper GI Tract	116
Gastrointestinal System:	
Foreign Bodies in the Upper GI Tract	116
Geriatrics:	
Mortality of Elective Abdominal Aortic Surgery in Oc- togenarians	154
Gynecology:	
Guidelines for Level III Perinatal Centers in Kansas .	12
Maternal Health Committee: Maternal Mortality Re- view	338

Role of HSV & HPV in Cervical Cancer, The	113	Proximal Tibial Valgus Osteotomy	267
Urethral-Hymenal Fusion & Recurrent UTI	150	Neonatology:	
Hematology:		Surfactant Supplementation Trial: Interim Analysis ..	314
Idiopathic Thrombocytopenic Purpura in Children ...	317	Nervous System:	
Immune System:		Alzheimer's and the Extended Patient	55
Evaluation of Clinical Immunologic Tests	85	Brainstem Auditory Evoked Potentials in Dizziness ..	121
Penicillin Allergy Update	78	Epilepsy and Driving Privileges	81
Post-Splenectomy Sepsis	119	Hypnotherapy for Chronic Pain	190
Impaired Physicians:		Neurocysticercosis	227
To Help a Sick Friend	322	Total Spinal Anesthesia — A Complication of Inter-	
Infectious Disease & Virology:		costal Nerve Block	84
Neurocysticercosis	227	Neurology:	
Post-Splenectomy Sepsis	119	Alzheimer's and the Extended Patient	55
Ribavirin: Case Reports & Discussion	43	Brainstem Auditory Evoked Potentials in Dizziness ..	121
Role of HSV & HPV in Cervical Cancer, The	113	Epilepsy and Driving Privileges	81
Internal Medicine (see also under subspecialties):		Hypnotherapy for Chronic Pain	190
Postinfarction Myocardial Rupture	195	Neurocysticercosis	227
Alzheimer's and the Extended Patient	55	Obstetrics:	
Anatomy of an Epidemic	142	Guidelines for Level III Perinatal Centers in Kansas .	12
Cardiac Resuscitation in Rural Kansas	187	Maternal Health Committee: Maternal Mortality Re-	
Epilepsy and Driving Privileges	81	view	338
Evaluation of Clinical Immunologic Tests	85	Upgrading Regionalized Perinatal Care in 1987	10
Kansas:		Orthopedics, Physical & Sports Medicine:	
House of Representatives	4	History of Orthopedic Surgery at UKSM-KC, A	223
House of Representatives District Map	8	Proximal Tibial Valgus Osteotomy	267
Legislative Leadership	1	Otolaryngology:	
Senate	4	Asthma Complicated by Sinusitis	46
Senate District Map	6	Brainstem Auditory Evoked Potentials in Dizziness ..	121
KFMC:		Pathology, Laboratory & Forensic Medicine:	
Update	112, 140, 233, 282	Evaluation of Clinical Immunologic Tests	85
KMS:		Pediatrics:	
Annual Meeting Sponsors	234	Asthma Complicated by Sinusitis	46
Auxiliary News	106, 148, 258	Guidelines for Level III Perinatal Centers in Kansas .	12
Constitution and By-Laws	344	Idiopathic Thrombocytopenic Purpura in Children ...	317
Council District Reports	216	Ribavirin: Case Reports & Discussion	43
Council Meetings	93, 252, 336	Surfactant Supplementation Trial: Interim Analysis ..	314
House of Delegates Official Proceedings	209	Upgrading Regionalized Perinatal Care in 1987	10
Nominating Committee Report	71, 108	Personal View, A:	
Public Affairs Staff Added at KMS	306	In Search of a Health Care System for Farmers	27
Medical Economics:		Unification Revisited: Taxation without Representation	33
Malpractice '87: Status and Solutions	261	If Not the AMA, Who?	66
New Tax Law: Hidden Effects on Life Insurance Pol-		And We Shall Be Led by Hindsight	98
icies	324	A Response to "Who Determines Quality?"	110
Medical Education:		Pharmacology, Therapeutics & Toxicology:	
Graduate Followup of UKSM-KC Family Practice Res-		Idiopathic Thrombocytopenic Purpura in Children ...	317
idency Training	155	Penicillin Allergy Update	78
History of Orthopedic Surgery at UKSM-KC, A	223	Ribavirin: Case Reports & Discussion	43
Stress Management in Residency Training Programs .	162	Physician Impairment:	
Medical History:		Stress Management in Residency Training Programs .	162
Anatomy of an Epidemic	142	To Help a Sick Friend	322
History of Orthopedic Surgery at UKSM-KC, A	223	Psychiatry & Psychology:	
Men of Their Time	21	Hypnotherapy for Chronic Pain	190
Medical Oncology:		Stress Management in Residency Training Programs .	162
Facing Cancer Together: A Volunteer Program for Small		Public Health & Community Medicine:	
Communities	159	Cardiac Resuscitation in Rural Kansas	187
Role of HSV & HPV in Cervical Cancer, The	113	Epilepsy and Driving Privileges	81
Medicina et Lex:		Facing Cancer Together: A Volunteer Program for Small	
Drug Dispensing	25	Communities	159
Reflections upon the Social Implications of Medical		Guidelines for Level III Perinatal Centers in Kansas .	12
Malpractice Litigation	50	Health Care Stewardship	196
Chiropractors and Staff Privileges	90	Male Contraception and AIDS Prevention: The Need	
Patient Records	127	for Involvement by Kansas Physicians	193
Antitrust Immunity for Reviewers	166	Upgrading Regionalized Perinatal Care in 1987	10
May the Health Care Stabilization Fund Settle a Claim		Pulmonary Medicine:	
over a Physician's Objection?	201	Surfactant Supplementation Trial: Interim Analysis ..	314
New Law Allows Exempt License	232	Radiology, Nuclear Medicine & Magnetic Resonance	
Collateral Source Statute Held Unconstitutional	273	Imaging:	
The Liability of Drug Manufacturers and Physicians .	298	Neurocysticercosis	227
Medicolegal Activities:		Reproductive System:	
How to Avoid the "Failure to Diagnose" Claim	265	Male Contraception and AIDS Prevention: The Need	
Malpractice '87: Status and Solutions	261	for Involvement by Kansas Physicians	193
Musculoskeletal System:		Role of HSV & HPV in Cervical Cancer, The	113

Urethral-Hymenal Fusion & Recurrent UTI	150
Respiratory System:	
Asthma Complicated by Sinusitis	46
Ribavirin: Case Reports & Discussion	43
Respiratory System:	
Surfactant Supplementation Trial: Interim Analysis ..	314
Rheumatology:	
Proximal Tibial Valgus Osteotomy	267
Socioeconomic Medicine & Health Care Delivery:	
Health Care Stewardship	196
How to Avoid the "Failure to Diagnose" Claim	265
Special Senses:	
Brainstem Auditory Evoked Potentials in Dizziness ..	121
Surgery:	
Mortality of Elective Abdominal Aortic Surgery in Oc-	
togenarians	154
Post-Splenectomy Sepsis	119
Proximal Tibial Valgus Osteotomy	267
Urinary System:	
Urethral-Hymenal Fusion & Recurrent UTI	150
Urology:	
Male Contraception and AIDS Prevention: The Need	
for Involvement by Kansas Physicians	193
Urethral-Hymenal Fusion & Recurrent UTI	150
Vox Dox	135, 220, 250, 339

EDITORIALS

Reaction to Accommodation	24
The Unrelenting Obligation	49
Locum Tenens	89
The Right Stuff	126

Spreading the Word	165
Uncertain Certainties	200
Owed to the Virus	231
Dilemma du Jour	272
The Necessary Evil	280
<i>Mens Sana in Corpore Sano</i> , We Hope	310
Convenience or Conflict?	334

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Prevention of hypokalemia requires particular attention in patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis and ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, certain diarrheal states, or other states where hypokalemia is thought to represent particular added risk to the patients.

In patients with hepatic cirrhosis and ascites, sudden alterations of electrolyte balance may precipitate hepatic encephalopathy and coma. Treatment in such patients is best initiated in the hospital with small doses and careful monitoring of the patient's clinical status and electrolyte balance. Supplemental potassium and/or spironolactone may prevent hypokalemia and metabolic alkalosis in these patients. In cats, dogs and guinea pigs, Bumex has been shown to produce ototoxicity. Since Bumex is about 40 to 60 times as potent as furosemide, it is anticipated that blood levels necessary to produce ototoxicity will rarely be achieved. The potential for ototoxicity increases with intravenous therapy, especially at high doses.

Patients allergic to sulfonamides may show hypersensitivity to Bumex.

PRECAUTIONS: Measure serum potassium periodically and add potassium supplements or potassium-sparing diuretics, if necessary. Periodic determinations of other electrolytes are advised in patients treated with high doses or for prolonged periods, particularly in those on low salt diets.

Hyperuricemia may occur. Reversible elevations of the BUN and creatinine may occur, especially with dehydration and in patients with renal insufficiency. Bumex may increase urinary calcium excretion. Possibility of effect on glucose metabolism exists. Periodic determinations of blood sugar should be done, particularly in patients with diabetes or suspected latent diabetes. Patients should be observed regularly for possible occurrence of blood dyscrasias, liver damage or idiosyncratic reactions.

Especially in presence of impaired renal function, use of parenterally administered Bumex should be avoided in patients to whom aminoglycoside antibiotics are also being given, except in life-threatening conditions.

Drugs with nephrotoxic potential and bumetanide should not be administered simultaneously. Since lithium reduces renal clearance and adds a high risk of lithium toxicity, it should not be given with diuretics.

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Bumetanide may be excreted in breast milk.

Pediatric Use: Safety and effectiveness below age 18 not established.

ADVERSE REACTIONS: Muscle cramps, dizziness, hypotension, headache and nausea, and encephalopathy (in patients with preexisting liver disease).

Less frequent clinical adverse reactions are weakness, impaired hearing, rash, pruritus, hives, electrocardiogram changes, abdominal pain, arthritic pain, musculoskeletal pain and vomiting.

Other clinical adverse reactions are vertigo, chest pain, ear discomfort, fatigue, dehydration, sweating, hyperventilation, dry mouth, upset stomach, renal failure, osteitis, itching, nipple tenderness, diarrhea, premature ejaculation and difficulty maintaining an erection.

Laboratory abnormalities reported are hyperuricemia, azotemia, hyperglycemia, increased serum creatinine, hypochloremia, hypokalemia, hyponatremia, and variations in CO₂ content, bicarbonate, phosphorus and calcium. Although manifestations of the pharmacologic action of Bumex, these conditions may become more pronounced by intensive therapy. Diuresis induced by Bumex may also rarely be accompanied by changes in LDH, total serum bilirubin, serum proteins, SGOT, SGPT, alkaline phosphatase, cholesterol, creatinine clearance, deviations in hemoglobin, prothrombin time, hematocrit, platelet counts and differential counts. Increases in urinary glucose and urinary protein have also been seen.

DOSAGE AND ADMINISTRATION:

Oral Administration: The usual total daily dosage is 0.5 to 2.0 mg and in most patients is given as a single dose.

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